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ABSTRACT

This training model is a guide for developing statewide training for a continuing education certificate in gerontology in religion and aging. It is designed for use by gerontology educators, state office of aging executives, and leaders of religious judicatories. Section I begins with a description of the training model and covers where and how to begin. Chapter 2 focuses on the course format, schedule, requirements, and modifications. Chapter 3 deals with the central focus of the training: building collaborative relationships and using the course content in projects that extend programs and services to older persons in the communities. The chapter covers a project planning process and using the resources of good community involvement, older volunteers, and advisory committees. Chapter 4 provides information on research instruments and research report results and their use for planning and evaluation. Section II introduces the recommended curriculum content. Each chapter covers one area and identifies content issues and suggested resources. Concepts include the following: biological, social, and psychological processes of aging; similarities and differences in the organizational structure and function of congregations and aging agencies; community and congregational programming; community resources; counseling older persons and their families; and policy issues. Section III summarizes the model. Appendixes include selected examples of projects and a sample area agency annual plan. (YLB)

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The Statewide Training Model for a Continuing Education Certificate in Gerontology in Religion and Aging

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THE STATEWIDE TRAINING MODEL FOR A CONTINUING EDUCATION CERTIFICATE IN GERONTOLOGY IN RELIGION AND AGING

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INTRODUCTION

The formal organizations that impact the lives of most older adults are churches and synagogues (Payne, 1985). Clergy and their congregations have more opportunities and resources to serve older people in neighborhoods than any other agencies. According to Palmore (1980), "Churches and synagogues are the single most pervasive community institutions to which the elderly belong." They serve more older persons than all other community organizations, clubs, senior centers, unions combined.

Furthermore, older people report high confidence in church programs and that they are much more likely to participate in church programs than public sponsored programs (Harris, 1981; Presbyterian Panel, 1980).

Churches and synagogues are graying at a rate three times faster than the general population. National Protestant denominations, Catholic and Jewish agencies report that 18% to 35% of their members are over 65 years of age. On a national level, most of the major faiths have made responses to the dramatic increase in older members: adopting aging policy statements; holding national symposia, (Episcopal, Lutheran); telecasts, (Episcopal); task forces, (United Methodist); establishing offices of aging, (Presbyterian, Southern Baptist); family or human services, (Unitarian, Universalists, Catholic, Jewish). However, the translation of these national initiatives into local congregational programming is slow, sporadic, and reveals the need for the training of clergy and other congregation leaders.

The clergy's training in aging and the age of the congregations they serve indicate the clergy's need to: (1) upgrade their knowledge and skills to effectively serve aging members; (2) acquire information about community resources for older persons; and (3) establish a relationship with aging agency staff.

The aging network, established by the Older American's Act of 1965, and other community or state agencies that serve older persons have more experience in developing and delivering services to older persons than any other community organization. As the focal point for aging services at the local level, Area Agencies on Aging (AAA) have resources and services in place throughout every state to assist clergy in congregational planning for their graying membership.

The increased demand for services from a burgeoning older population, and the decreased level of funding from federal, state and local governments, has created a growing need within the aging network and other agencies serving older persons for

new resources and ways to deliver services. They need the volunteers and organizational networking congregations could provide to extend services. There is a growing recognition by the aging network, at every level, of the significant role that clergy and their congregations can play in delivering support services for older persons, especially the frail elderly.

Congregations reach a broad, numerically large constituency that generally knows very little about the aging network or available services. Congregations therefore become a major source of professional persons and other volunteers who are able to tap new resources for meeting needs and new sources for locating older persons who have needs that are not being met.

Tobin, et al. (1986) observe that the elderly are benefited by minimal levels of interaction and cooperation among churches and synagogues and service agencies. Clergy who become aware of the needs of the elderly in their congregations find that they cannot respond to all the needs. The AAA's that provide services needed by congregational elderly find that they are limited in funds and resources. Tobin, et al. (1986) identified seven benefits to working together: (1) it allows a pooling of financial and human resources; (2) it enables a sharing of gifts; (3) it insures adequate numbers of participants in programs; (4) collaboration with a local service agency may provide the expertise to run a program well; (5) it can provide greater access to people who are in need that would not otherwise seek such help; (6) it allows each group to assess the types of services available in the community; and (7) it facilitates referrals between groups.

Most clergy lack any gerontological education or training in the role, function and availability of information and services about community agencies or the aging network. Most agency personnel lack training in the role and functions of pluralistic religious organizations. As a result, very little collaborative work has existed between religious congregations and agencies serving older persons.

There is a clear need to explore ways the aging network and other agencies serving older persons can find common ground with religious congregations that will extend programs and services to older persons and reap benefits for both, as well as the whole community. This is a natural alliance, because most agency staff are church or synagogue members, and the clergy are citizens concerned about community services for the elderly. Programs are needed to link the clergy, congregational leaders, the AAA's and other community aging agencies in a partnership of services with, by and for older persons--a partnership long overdue.

DEVELOPMENT OF A STATEWIDE TRAINING MODEL

The Statewide Training Model (STM) was developed for the purpose of providing a Continuing Education Certificate in Gerontology in Religion and Aging. The training centered on gerontology and coalition building, resulting in clergy and agency staff collaboration that extends programs and services by, for, and with older persons in the state. The training links clergy and agency staff in a new community partnership of services to older persons and builds a statewide network for future collaborative efforts.

The use of inclusive language in regard to promotion of the training was determined by a group of religious leaders, Jewish, Catholic and Protestant. It was felt by Jewish participants that the term clergy was inclusive enough to cover rabbis and ordained ministers or priests. However, the terms minister and ministry are not inclusive but offensive to some faith groups.

STATEWIDE TRAINING MODEL DESIGN (STM)

The STM design is a collaborative one that pulls together educational, agency, and religious organization leadership, and community resource persons throughout the state. Responsibility for delivering and monitoring the training rests with the gerontology educator and a statewide advisory committee of agency and religious organization leadership. Selection of six training sites was based on agency training needs, religious organization leadership, community resources and the availability of competent gerontology educators in those geographic areas.

A site coordinator (Area Agency on Aging staff) and a faculty coordinator (gerontology educator) were chosen for each site. The project training team was formed from these persons, three faculty persons who delivered parts of the curriculum in every site, and the Gerontology Center staff.

Recruitment of participants was targeted to clergy in churches and synagogues and to aging network staff, service providers and staff of other government or community agencies who work with older persons. Some lay volunteers were recruited, but effectiveness of the training rests with clergy participation.

The model is designed around two units of curriculum delivered in six eight-hour days of instruction (three days per unit). The two units are separated by an interim period during which participants begin developing collaborative clergy and agency staff projects. The first unit focuses on a basic understanding of the aging process (social, biological, psychological) as well as on understanding of pluralistic religious organizations, the contribution of the Black Church,

the aging network, and principles of community and congregational collaboration.

The second unit covers counseling issues, intergenerational family issues, gender differences, death, bereavement, elder abuse, housing, age discrimination in employment and legal issues. Federal agency, national organization and community resources are explored, including Social Security, Supplemental Security Income, Medicare, Medicaid, insurance counseling, American Association of Retired Persons' resources, Older Women's League resources, leisure and recreation. Case studies and structured discussions are used to facilitate application of content to practical situations. A second interim period, prior to the final session, allows participants to continue developing and implementing the collaborative projects.

Development of collaborative projects between clergy and aging agency staff is central to this training model. These projects offer a structured opportunity for building trusting relationships necessary for effective and lasting working relationships. The project must be based on real need and must extend services and programs to older persons in congregations or the community in new collaborative ways.

A final session, to which all participants come, includes a major content presentation, a showcase of the collaborative projects, and a ceremony to award the certificates. This session should be attached to a statewide gerontology professional meeting for maximum impact. At this final session participants see their efforts having statewide impact on extending programs and services to older persons in communities. A bonding occurs for a new statewide network for future collaborative efforts.

RESEARCH REPORT

A research report was made that includes a survey of clergy statewide and pretest, posttest data from participants. An opinion scale for use with clergy was developed and tested. These instruments with the research report can provide useful data for planning and evaluation in other training based on the STM.

REPLICATIONS OF THE STATEWIDE TRAINING MODEL

Two replications of the STM were completed in the state following the initial training year. These sites allowed modification of the model and yielded data essential for developing this Training Manual. These two replications were highly successful. A significant learning was that the state and site advisory committees are essential to the success of the

training.

THE TRAINING MANUAL

This Training Model is to be used as a guide for developing statewide training for a Continuing Education Certificate in Gerontology in Religion and Aging. It is designed to be used by gerontology educators, state office of aging executives, and leaders of religious judicatories.

Section I, The Training Model, begins with a description of the model and covers where and how to begin, namely, with the statewide advisory committee. Chapter 2. focuses on the course format, schedule, requirements and modifications. Chapter 3, Collaborative Projects, deals with the central focus of the training: building collaborative relationships and using the course content in projects that extend programs and services to older persons in communities. This chapter covers a project planning process and using the resources of good community involvement, older volunteers, and advisory committees in project development. Chapter 4. provides information on research instruments, research report results and how they may be used for planning and evaluation.

Section II introduces the recommended curriculum content for the STM. Each chapter of this section covers one area with identification of content issues and suggested resources. These chapters are intended to delineate a basic curriculum for the Continuing Education Certificate in Gerontology in Religion and Aging. The approaches presented are only intended to suggest ways to develop each area. Gerontology educators may want to supplement this content in many ways.

Section III looks at follow-up to the Statewide Training Model. The training produces collaborative networks on state and local levels that can support replication of the training or advanced continuing education.

Policies and programs that encourage public and private community agency and religious organization partnerships are timely and urgently needed. Such partnerships can be mobilized for efficient and effective use of resources to meet community needs.

The Statewide Training Model project has demonstrated effective clergy and agency staff training that results in productive collaboration for the benefit of older persons. Through this continuing education program, clergy have gained knowledge of existing agency services, and agency staff have developed an understanding of pluralistic religious organizations and how to work with them.

The significance of the Statewide Training Model project is that it bridges the separation of church and state in acceptable ways for the benefit of older persons and communities. Throughout the state, networks have been built for community, congregation, agency and business collaboration that will have permanent yet growing effectiveness in extending services and programs to older persons.

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SECTION I: THE STATEWIDE TRAINING MODEL

The Statewide Training Model (STM) is based on a project design that calls for the educational institution and gerontology educator, with an advisory committee, to be responsible for delivering and monitoring the training curriculum in at least five sites in a state. The STM Project Advisory Committee can be composed of state office of aging leaders as well as leaders of statewide and local religious organizations. This is a collaborative design that pulls together educational, agency, religious organization leadership and community resource persons in each of the geographic areas in which training sites are located to deliver the training.

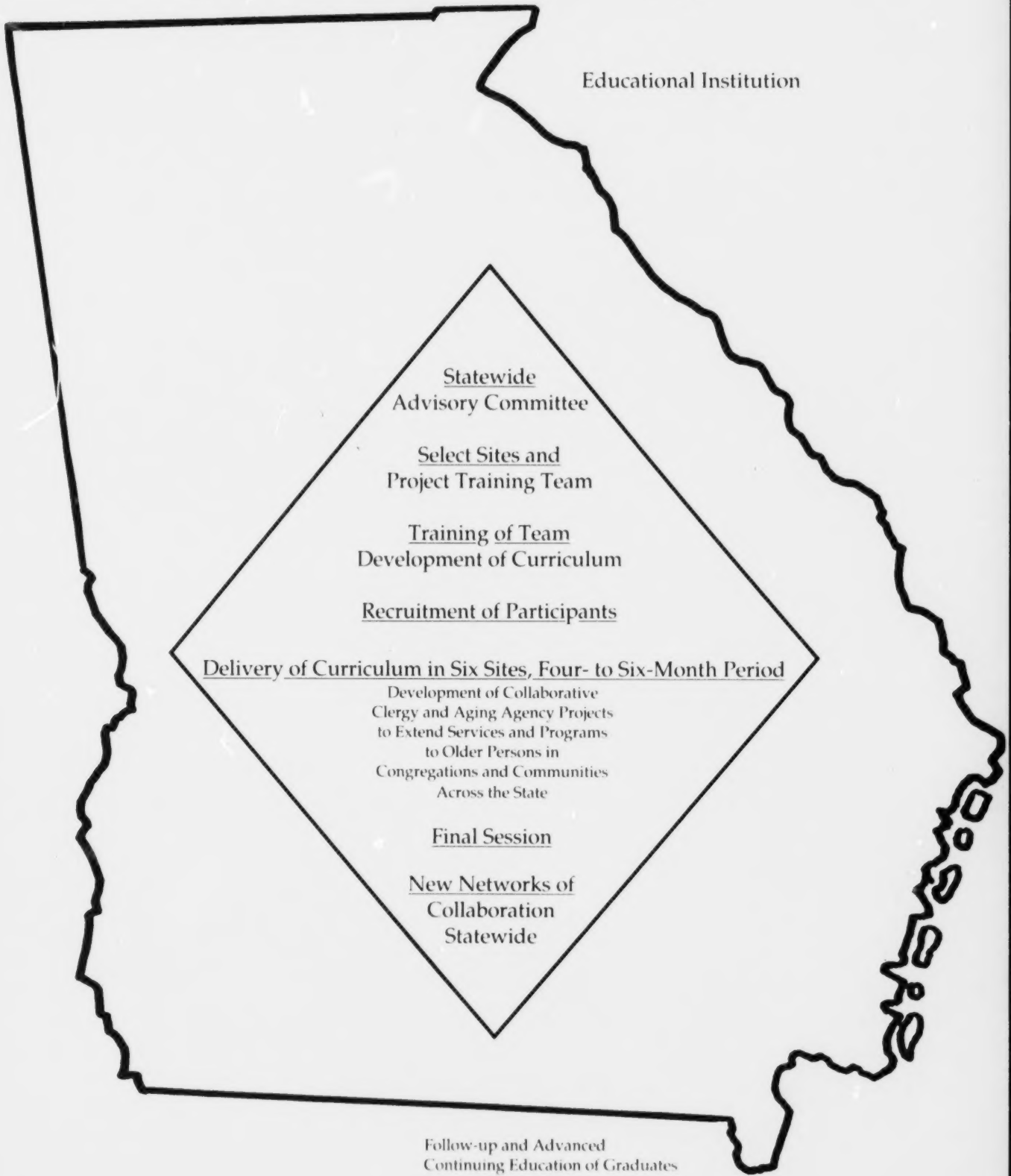
An organizational chart of the project design would be similar to a diamond shape. Figure 1 is a representation of the STM project design. The organizational method begins with one or more gerontology educators at an educational institution capable of offering a continuing education certificate in gerontology. The lead gerontology educator, in consultation with top agency and religious organization leaders, calls together a statewide advisory committee (15-25 persons) to give continuing leadership and support to the development and monitoring of the project. After selection of the training sites across the state and a team of site and faculty coordinators for each site, training and consultation with the entire project training team begins. The training team would also include additional faculty for each site.

Site-faculty coordinator teams, with assistance as needed from statewide advisory committee members, establish site advisory committees to carry functions similar to the statewide advisory committee: review curriculum and identify community resource persons to assist in its delivery; assist in recruitment of participants; and identify any fiscal or other community resources needed to offer the training.

Recruitment of participants is conducted statewide from the aging network, other aging agency staff and clergy from as many religious organizations as possible. Site advisory committees function to supplement that recruiting effort to assure a complete and balanced participant group (15-20 clergy and 10-15 agency staff). Each site is intended to pull together participants from a natural geographic area within 40-50 miles of the training location.

The training curriculum is delivered in six eight-hour sessions, two interim periods and a final session spread over a 4-6 month period. A major course requirement for each participant is development of a collaborative clergy and agency staff project that extends services and programs to older persons

Figure 1. The Statewide Training Model Design



in congregations and communities (central portion of Figure 1). The final session pulls together all of the participants from each site for a major content session, reporting and showcasing of projects and awarding the certificates. It is at this time that bonding of the participants into a statewide network of collaboration occurs as the impact of their efforts on extending programs and services to older persons throughout the state is realized.

The collaborative design of this project effectively links gerontology educators and statewide aging agency and religious organization leaders. It links similar leadership within natural geographic areas of a state. It extends their effectiveness through training clergy and agency staff who develop new partnerships in reaching older persons, previously unserved or underserved, with programs and services. The project design then pulls that trained leadership together in an experience that functions to create a new network of collaboration throughout the state.

There is a research dimension to the STM that will provide data for planning and evaluation. Pretest instruments have been developed and tested along with a body of data for use in interpreting new research results.

CHAPTER 1. THE BEGINNING: A STATEWIDE ADVISORY COMMITTEE

Barbara Thompson, MDiv, MS

The Statewide Training Model for a Continuing Education Certificate in Gerontology in the field of Religion and Aging is intended to respond to the need for religious communities, the aging network and community agencies to develop a partnership in delivery of programs and services to the expanding numbers of older persons in the population. This program is aimed at maximizing efforts and resources through using existing services and natural groupings of persons in innovative ways. In order to accomplish that purpose, this training program targets the key leadership involved: clergy and aging agency staff in local communities.

WHO SHOULD BE INVOLVED

1. Church and synagogue pastors and rabbis who can give authorization for collaborative efforts and give leadership support and commitment through the training for programs and projects locally;

2. Staff from aging agencies, Area Agencies on Aging (AAAs), Department of Family and Children Services--Adult Protective Services (DFACS), and other community agencies that provide services and programs for older persons;

3. A local institution of higher education that has faculty capable of dealing with the field of gerontology and granting a continuing education certificate in gerontology.

WHO SHOULD INITIATE THE TRAINING

Any one of the three major actors could initiate the training, for example, state offices of aging, the educational institution with a gerontology program, or religious judicatories in the state. However, no one group should develop the training alone.

The purpose of the training is to establish local exchange between agency and clergy persons that will lead to appropriate extension of programs and services to older persons in new ways that increase their quality of life. Training in aging plus collaborative action at the local level between clergy and agency staff, and eventually their constituent groups, is the goal.

Involvement of all three groups is necessary from the beginning to achieve the purpose and goal of the training program. Although course design should rest with the educational institution, input from the state offices of aging and religious judicatories on needs and resources will be essential. A college or university with a gerontology program is the best resource for content development. To locate such an institution in a state or specific community, consult an Association for Gerontology in Higher Education Directory of Educational Programs in Gerontology available in most college or university libraries, or contact AGHE directly:

600 Maryland Ave., S.W.
West Wing Suite 204
Washington, D.C. 20024

For best results, extensive presentation of the course to state area agency on aging (AAA) leaders, state office of aging staff, staff in the Department of Family and Children Services who work with Adult Protective Services and to representative religious bodies will be important for their support and their input to planning. These areas would include:

1. Input on the best location of the training sites statewide;

2. Particular needs of their constituencies;

3. Availability of resources and local support.

It is important that the course provide continuing education unit credit (CEUs) for participants. Some religious judicatories require their members to do a certain number of units each year. It is also important for the professional development of all participants, but agency personnel in particular, that the course meet requirements for a Continuing Education Certificate in Gerontology in Religion and Aging.

This Training Manual is written to assist state offices of aging, educational institutions or national and state religious organizations in taking the primary initiative for developing a statewide program. Due to the pluralistic nature of the religious community locally and statewide, successful initiation from that population could come from a seminary continuing education program. In any case, leadership from an educational institution would provide a neutral ground for designing and pulling together resources.

THE ESSENTIAL INGREDIENT: STATEWIDE AND LOCAL ADVISORY COMMITTEES

A statewide advisory committee composed of representatives of each of the three groupings is strongly recommended. The advisory committee becomes an essential communication link between diverse religious groups and agencies involved in the training. With a focus on collaborative effort in the certificate program, input to the development of the curriculum, identification of resources and recruitment of students must rest with representatives of all three types of groups. The statewide advisory committee also can be helpful in identifying leadership for local advisory committees for each training site. It is recommended that the advisory committee range between 15-25 members.

TIMING FOR THE STATEWIDE ADVISORY COMMITTEE

Organization of the statewide advisory committee should precede the initiation of the program. This assures balanced planning, ownership and clear responsibility for the program. The committee can grow in numbers as the ideas for the program take shape. The important factor is the balance of representation among the three constituencies.

Adequate planning time will be important to the success of the training effort. It takes sufficient lead time in order to secure commitment and data from all three groups necessary for decisions about proceeding. A multitude of planning questions will have to be faced, such as:

1. How will this particular training program benefit the agencies involved? The religious organizations? The educational institution?

2. What kind of formal endorsement or commitment from constituent groupings is needed?

3. What will the program cost?

4. What are the possible sources of funding? What is the best way to approach funding?

5. How long will the initial project development process take?

6. What kind of time table should be followed for determining site locations, site-faculty teams, curriculum development, formation of local advisory committees, and recruitment of participants?

7. When is the best time of the year to hold such training?

8. Who will be responsible for coordinating and directing the training? When and how will this person be chosen?

Answers to these questions will determine the kind of meeting schedule, structure and size of the advisory committee needed to accomplish the planning process and special functions of the committee.

SELECTION OF STATEWIDE ADVISORY COMMITTEE MEMBERS

Top leadership of major statewide religious judicatories, executives of the state office of aging and other statewide aging agencies should be consulted and perhaps invited to membership on the committee. Several key faculty members from the educational institution who will be involved in the program should also serve on the committee. A balance between the three groups will be important. As the committee begins its work additional persons may be added as needs develop.

Some basic criteria for selection might be:

1. Persons who can appropriately represent each of the three groupings in regard to authority and leadership within that group;

2. Persons who are knowledgeable about resources statewide, that is persons, places and potential local sponsors of the training;

3. Persons who are willing to explore this new training opportunity and willing to make some commitment of time and energy to its development.

STATEWIDE ADVISORY COMMITTEE FUNCTIONS

Site Selection. The first function is identification of training and resources within the state that can lead to selection of instruction sites and faculty and site teams. It is recommended that at least five sites be chosen in various parts of the state in order that a statewide impact on extension of programs and services can be made.

Review Curriculum. Although a faculty member from the educational institution should have responsibility for the development of the curriculum content, the advisory committee

should review the basic curriculum and give input for making it relevant to their clergy and agency staff needs.

Identify Resources. A major function is identification of resources of all types, for example, resource persons for local site committees and curriculum delivery; local sponsorship for financial or in kind resources, depending upon how the program will be funded.

Recruitment. The recruitment of participants must be undertaken by everyone involved in the planning of the program. Specifically, a brochure or other publicity material will need to be developed and reviewed by the advisory committee. Lists of clergy and agency staff will need to be secured from all religious groups and agencies. This function includes networking to secure participants and making appropriate contacts necessary to get time released for participant attendance, especially for agency personnel.

CHAPTER 2. SCHEDULE OF THE COURSE

Barbara Thompson, MDiv, MS

RATIONALE

The goals of the Continuing Education Certificate in Gerontology in Religion and Aging are multiple:

1. To build collaborative relationships between clergy and agency staff that will result in extension of services to older persons in congregations and communities;

2. To upgrade the knowledge base of both clergy and agency staff in the field of aging;

3. To provide a training experience that will deliver the content and application of learning necessary to earn the designation of Continuing Education Certificate in Gerontology, and give sufficient CEU credits to compel participants to enter the course.

COURSE REQUIREMENTS

1. Attendance: Attend all scheduled sessions of the course (56 hours of instruction in six instruction days and the final session).

2. Readings in required texts:

   Atchley, R. (1987). Aging: continuity and change. Belmont, CA: Wadsworth Publishing Company.

   Tobin, S., Ellor, J., Anderson-Ray, S. (1986). Enabling the elderly. Albany, NY: State University of New York Press.

   Journals and popular articles as indicated.

3. Projects:

   Plan, develop and operationalize a collaborative project between clergy and agency staff with other course participants or with a congregation or agency staff person in the community that extends programs and services by, for, and with older persons. Submit reports as requested.

4. Interim Activities:

   Complete readings and develop the project between the sessions. Report progress to the site coordinator or a designee. Consultation will be available with faculty or resource persons.

5. Final Session:

   Attendance at the final session at which the certificates will be awarded.

   It is recommended that a course syllabus be developed and handed out to participants on the first day of the course. If a gerontology library is not available to course participants, it is recommended that journal articles , popular articles and appropriate chapters in books be xeroxed for their use. For continuing education students, access to an educational institution library may be difficult.

The use of six eight-hour days of instruction with the requirement for developing a community project is a format based on experience with other certificate courses offered by the Gerontology Center at Georgia State University. This format provides enough hours to cover the curriculum content necessary for a continuing education certificate in gerontology. The day long session lends itself to a mixed use of lecture, films, panels or other methods for delivery of content on aging processes, aging issues and community resources. It also provides workshop time for use of case studies and discussion periods to explore application of that content.

The eight-hour session once a week for several weeks has some recruitment advantages. Clergy can often arrange their day off to coincide with the course schedule. If not, they can usually arrange their personal schedule to accommodate blocks of time. Many agency staff prefer to arrange a whole day off rather than a few hours several times a week. This requires careful explanation of the advantages of the course to agency supervisors and commitment of agency administrators to allow time off for continuing education. Most participants have indicated that the eight-hour day promotes learning through the intensive focus on topics. Participants seem able to let go of daily work concerns and not feel as pulled between course time and office time.

DAYS OF INSTRUCTION

The training model provides 60 hours of instruction for 6 Continuing Education Unit credits. The schedule suggested is as follows:

1. Six eight-hour days of instruction divided into two curriculum units spread over a 2 1/2 to 4 month period provides 48 hours of instruction, e.g., three successive Mondays or Tuesdays in February for unit 1 and three successive Mondays in April or May for unit 2;

2. Two interim periods for participant work on project development in the community, with consultation by faculty or designated persons, provides approximately 4 hours of instruction, e.g., 4-6 weeks between unit 1 and 2, and 4-12 weeks from end of instruction to final session;

3. A final session of 8 hours draws together all course participants for a major content session followed by participant presentation of projects and awarding of the certificates.

The first 3 day unit of instruction is designed to provide the foundation for the whole course. Curriculum content covers:

1. An overview of the current demographic situation with a socio-community gerontological interpretation of the data;

2. An understanding of the social and biological aspects of the aging process;

3. Pluralistic organization of the religious community including the contribution of the Black Church;

4. The Older Americans Act and the Aging Network in the community;

5. The function and planning process of the collaborative participant projects;

6. Principles of community and congregation cooperative programming.

The second three-day unit of instruction continues a grounding in the field of gerontology but includes more emphasis on aging issues and application of learnings to practical situations. Curriculum content covers:

1. Psychology of aging;

2. Counseling issues;

3. Aging issues such as health care costs, elder abuse, death, dying and bereavement, housing and relocation, employment, age discrimination, legal concerns, gender

differences, problems of older women, intergenerational and family issues;

4. Federal agency, selected national organization, community and agency resources, for example, Social Security, Supplemental Security Income, Medicare, Medicaid, insurance counseling, Older Women's League, American Association of Retired Persons, leisure and recreation resources;

5. Application through case studies, structured discussions and project planning.

TWO INTERIM PERIODS FOR PROJECT DEVELOPMENT

A major purpose of the course is building collaborative relationships between participants that will result in extension of programs and services to older persons in communities. In order to do this, agency staff need to learn the language, problems and organizational style of clergy. They must explore the pluralistic organizational systems operating among the religious community and how to access those systems in effective ways. Clergy in similar fashion, need help in understanding agency operations, agency resources available to them and how to take advantage of them.

It should be noted that the morning and afternoon break periods as well as lunch are considered part of the instruction time. Experience with the model has shown that these periods provide invaluable networking opportunities for participants in developing their projects as well as informal discussion time related to curriculum content. For these reasons, it is important to keep the group together during those periods by providing break refreshments and a group luncheon.

An important product of the course is development of trusting relationships between clergy and agency persons as common needs and purposes are explored. These become the basis for lasting and effective collaborative efforts in the community.

Scheduling the course over a three week period, on successive days, for each unit allows time for reflection on the content and some routine commitment helpful in preparation for sessions. Many participants found they had situations during the week that called for learnings from the previous session.

The two interim periods are intended to provide time for participants to research, plan and begin their collaborative projects. The first interim between units 1 and 2 of the curriculum should focus on researching, clarifying project ideas, and identifying resource persons, agencies, churches, and others

who should be involved. The second interim period, which follows completion of the instruction days, focuses on implementation of the project or completion of any preparations necessary to implementation.

The requirement for developing a community project focuses the learning experience in a significant way. It provides another framework for integrating content and resources. In addition, it develops a meaningful structure for building collaborative relationships. The intensive time period of an eight-hour day of instruction builds group cohesion and allows time for both formal and informal networking of participants.

THE FINAL SESSION

The final session incorporates several functions related to closure of the course and offers the opportunity of planning with creativity and care. This is the only time that participants are brought together from all of the sites in the state. It is recommended that the session be held in conjunction with a statewide meeting of professionals in the field of aging such as a state gerontology society annual meeting or a state Office of Aging conference. The intention of the day is to provide closure that bonds the clergy and agency participants in a new statewide network for collaborative efforts.

The design of the day includes a major content presentation on current aging issues for the present and the future, such as, Religion, Health and Aging; Ethical Issues in Aging; Policy Issues in Aging. This sets the tone for thinking together about issues which face everyone in the state.

A large block of time showcasing the participant's projects is a highlight of the day. Here the participants begin to see that their efforts have made a real impact on extending services and programs throughout the state. As the momentum and excitement builds, even though the reporting process is short for each one, bonding of a new statewide network begins.

The final session provides closure for the program as all of the site efforts are pulled together and put in a statewide perspective. Awarding of the certificates becomes a meaningful activity to cap the day.

MODIFICATIONS

The training model is designed to deliver a heavy load of content in a relatively short period of time. However, experience with the model indicates that it can be used flexibly and adapted to special needs without sacrificing quality of the

educational experience. During the 1988 sessions, sites began and ended instruction periods when suitable for their geographic areas. For example, sessions in the Georgia mountains began two months later than other sites due to cold weather conditions but maintained the same course format.

The 1989 Columbus replication used a five day version of the model with success. Although content was not curtailed, some of the informal networking and discussion time was sacrificed. Both of the 1989 replications used a short second interim prior to the final session. The result was that many of the collaborative projects had not been implemented or had limited experience with implementation.

A major caution for those planning the curriculum is to be aware of the need to build-in discussion periods for looking at application of content presentations for projects. Time to explore issues relevant to participants that might not have been anticipated in content presentations is equally important.

With any modification of the model, requirements for granting of a certificate in gerontology and for continuing education unit credit necessary to the educational institution must be honored.

CHAPTER 3. COLLABORATIVE PROJECTS

Training for development of collaborative efforts between congregations and community agencies is central to this Continuing Education Certificate in Gerontology in Religion and Aging Model. This purpose is based on barriers to such efforts that have grown out of a public mindset about separation of church and state, a common attitude among religious congregations that "The church and synagogue should take care of its own," and a general distrust that any government funded services are for everyone. Clergy and agency staff barriers to collaborative efforts tend to be based on lack of knowledge of each others organizational language, systems, values and general ways of working. Most clergy are uninformed about the range of agency services available in the community. Most agency staff view churches and synagogues as a ready source of volunteers to carry out their programs. Clergy work may be a mystery to them.

The requirement that participants develop collaborative projects offers a structured opportunity for cutting through the barriers, dispelling myths about each other, building trusting relationships necessary to effective and lasting working together. It takes delivery of good information plus time to share and work on common understandings and purposes.

Collaborative projects can be either team efforts among participants or individual efforts. If the project is based on individual initiative, that person must recruit collaboration from either clergy or agency persons in their own community. In some cases teams might be based on two or more individuals from one agency who then will work together on involvement of clergy persons, other than course participants, to assist with the project. In like fashion, two or more clergy could work as a team, recruiting agency staff in their area to develop a collaborative approach to services and programs. Regardless of how the effort is structured, the collaborative project must be based on real need, must be do-able and must extend services and programs in congregations or the community in new collaborative ways.

The requirement for each participant to develop a collaborative project provides a structure for applying course learnings in a focused manner. In addition to giving the opportunity for using new knowledge, the project should provide a way for both clergy and agency staff to work on knotty problems they had been unable to solve. In many cases it may provide impetus for clergy to recognize previously overlooked needs of older congregation members.

The choice of topics comes from many sources. They grow out of a new awareness of needs or long term interests. They come

from thorny problems at work or recognition of new opportunities. They may come from personal experiences with elderly parents or friends. Whatever the source, each project requires time, effort and commitment of participants. They also require good planning skills.

A planning process is recommended with time in the curriculum for discussion and application of the methods. It is important that this process be introduced early in the course with a careful review in the third session prior to the first interim period. Three reports and a final written paper are required during the course. These grow out of the planning process and assist participants in developing an orderly approach to their projects.

The first interim period is provided as time for development of ideas, identification of resources and pulling together an advisory committee. The second interim is to be used for planning and beginning of implementation of the project.

During both interim periods, faculty or designated community resource persons should be available for consultation and assistance as needed. Many participants will not seek nor need this support. However, it is important that the site-faculty coordinators know what is being developed and suggest resources to participants as projects form. Faculty may be asked to serve on advisory committees or to be consultants to a planning team. In some instances faculty may be called on to function as field supervisors. Each project will have to be dealt with differently. In some cases community resource persons may provide the best assistance to participants.

The training experience has elicited a broad range of projects. Some projects have focused on development of program and services within congregations. Some projects have grown out of agency efforts to inform and offer training to congregations for use of services within their congregations. In some efforts, directories of services and programs have been researched and published. Workshops, conferences or seminars have been developed around housing decisions, wellness, and other areas of concern. Innovative intergenerational program has been developed. Agencies, churches and community groups have united to outfit a kitchen to provide meals for a large rural area. The possibilities are as great as the imaginations of the participants (See Appendix A).

At the final session participants see their efforts as a statewide impact on extending programs and services to older persons in communities. The experience offers recognition of the hard work spent on project development and a sense of being part of a much larger more significant and more permanent endeavor. These factors are essential to building a statewide network for

future collaborative efforts.

In retrospect, the lasting effects of the projects have had mixed results. Most of the projects have continued and grown. Some have faltered due to poor choice of topic, inaccurate identification of need, lack of time or commitment of participants, change of jobs or churches, or other reasons. On the other hand, new projects have developed out of the training experience many months later. The training experience has also built a statewide pool of community resources in support of future collaborative efforts and future clergy and agency staff training.

Evaluation comments by participants have indicated that the project requirement provided an in-depth learning experience. For many, it became the most exciting part of the course. Many have indicated they want the Gerontology Center to stay in touch and keep up with them.

CHURCH, SYNAGOGUE AND COMMUNITY PROJECTS

Catherine Healey, MSW

PROJECT PLANNING PROCESS

One goal of the Certificate in Gerontology in Religion and Aging is to demonstrate linkages of clergy and aging network personnel in a partnership of service with, by and for older persons. To qualify for the certificate in gerontology each student is required to conceptualize, plan, design and implement (if possible in the time frame of the class year) a project that involves cooperation between clergy, synagogues, congregations and social agencies serving older persons. The problem which the project addresses should be based on an identified community need for service, training or research. The project should also demonstrate knowledge of the basic concepts addressed in the curriculum and skill in network and coalition building between churches, synagogues, congregations, clergy, or providers of service to older persons (i.e.: AAA Staff, social agencies, council on aging). The project may involve one or more students within the class, as well as persons who are not in the class, but are in the community. If implementation is not possible within the class year, then the final written report should include an action plan and steps for implementation, as well as expected outcome.

PROJECT DESCRIPTION

The project will include but is not limited to the following items which are expected in three steps, each with a written paper. (note due date)

STEP 1: Due at third session: (Figure 2, Report Form, Item I) Conceptualization includes the following:

A. Clear statement of problem, including identification of need;

B. Purpose of project: what is the goal;

C. Scope of project: describe the geographic area, community, demographics, target population;

D. List persons, organizations, and agencies working in project area;

E. Literature review: begin bibliography and list of community resources to be used.

Figure 2.

Church, Synagogue and Community Project Planning: Report Form

Item I - Due at third session.

Describe project.

1. The project will address the following problem:

_____

_____

_____

_____

2. The project plans to accomplish the following:

_____

_____

_____

_____

3. The geographic area and population where the project will be done: _____

_____

_____

_____

4. List who will work on project and their affiliation:_____

_____

_____

_____

_____

Item II - Due at fourth session.

How project will be carried out.

1. What do you know about the project?

   Has it been done before?_____

   _____

   _____

2. What methods will be used to carry out the project?_____

   _____

   _____

   _____

3. Who is involved in project and what will each do?

   _____

   _____

   _____

   _____

4. What resources, (financial, volunteer facilities, etc.) are needed?

   _____

   _____

   _____

   _____

5. When will project begin?

   _____

   _____

   _____

Item III - Due at final session.

A. Final report on project. (A composite of pages one and two);

B. Presentation and discussion of project with other students and conference participants.

The interim period between the two units of instruction is to be used to determine methodology for implementation and development of the project with supervision from the site coordinators, instructor, or training staff.

STEP 2: Due at fourth session (Figure 2, Report Form, Item II) Methodology and Literature Research

A. Literature research should cover the following:

1. Current state of art;

2. Previous work in field;

3. How proposed project improves on or demonstrates important departure from existing practices.

B. Methodology: how you will carry out project

1. Concise statement of realistic goal;

2. Measurable objectives with action steps;

3. Time frame for action steps (time chart);

4. Projection for success;

5. Community resources (voluntary organizations, volunteers, churches, aging network agencies, corporations): list with whom you will network to assure success and continuation of project.

STEP 3: Due at final session (Figure 2, Report Form, Item III)

The final session will be devoted to summary presentations of each project by the participants, with review and evaluation from conference participants.

A. Final written paper which includes:

1. Statement of problem;

2. Goal of project;

3. Objectives;

4. Methodology;

5. Plan for implementation;

6. Barriers to success;

7. Results.

B. Final presentation and discussion of project with conference participants.

COMMUNITY INVOLVEMENT

Today, community involvement in human welfare is greater than it has been since our country was young and neighbors were busy helping neighbors. Furthermore, community involvement has not only increased, but has taken on a broader and deeper dimension. Community resources are being called on by more and more federal, state, and local government social agencies. With the growing awareness of the value and potential of community involvement, agencies, clergy and congregations should prepare themselves to effectively use this resource. They need to take the initial step, by doing "behind the scenes work". Getting to know the five "W's" (who, what, when, why, and where) puts one at tremendous advantage when seeking community involvement. By establishing through first hand knowledge WHAT the community needs and wants, you are able to determine WHY and begin construction of the foundation of your project. These needs and wants are validated through contacts in the community. Key contacts such as church groups, civic and social clubs, and individuals will be able to give information as to WHO will or can help. Better known as WHO are the people other people will listen to and follow. From this point on, organizing the specifics of the project will determine WHEN. One thing that must be stressed in depth: never exclude any groups or individuals because they may represent a different point of view. It is better to have them out in the open discussing their differences with you, than having them meeting in secret plotting otherwise.

These are but a few of the many undertakings required to establish a successful base of operation. There are many intangibles that are also required, such as sensing and saying the right thing at the right time and place, having an awareness of the ever changing temperament in your community and in your project, and being able to sell your project because you believe in it. Most important is the ability to sit down and talk with all people regardless of their position or status in the community. Some of the best ideas may come from the least likely individuals. Always be aware that people are people, regardless of size, shape, color, or ethnic background. They do care. They care enough to become involved if you'll only give them a chance.

The effective involvement of community resources which includes volunteers and advisory committee members, does not just happen. It requires sound planning and coordination based on proven standards of practice. Experience has shown that there

are basic criteria which are necessary to the successful involvement of the community.

The first criteria is administrative support. Administrative support means more than giving lip service to the program. It means a commitment on the part of the leadership to invest staff time, money and facilities when necessary for the operation of the project. For effective community involvement there must be agency, church or synagogue leadership.

The second criteria is staff. There must be one person who has the time and has been delegated the authority necessary to coordinate and guide the project.

The third criteria is community support. Without community support there can be no community involvement. From the community come the volunteers, committee members and definition of need for the project. From the community comes the ultimate financial support for the project. All community resources (human, financial and material), must be tapped to the fullest degree possible. The importance of service volunteers and an advisory committee in this process is essential.

The fourth criteria is volunteer support. Volunteer support is needed for the development of policies and procedures for supporting the advisory committee members or service volunteers in their efforts.

Training programs for volunteers are structured around the kinds of services the volunteer will give and the program you are establishing. Suggested areas of inclusion are sensitivity training, community relations, lay panels, professional panels, joint participation panels of volunteers and professionals, workshops touching on job assignments or general volunteer work activities, and special programs.

Procedures for evaluation and recognition. These should be planned with agency administration and members of the advisory committee. Evaluation is a valuable tool to use, to measure community involvement and the project progress. This means setting goals and objectives for the project and periodically taking a look at where you plan to go.

Develop procedures for record keeping. There is need to keep account of what volunteers are doing, where they are working, with whom they are working, and how much time is being spent in volunteer service.

Analyze yourself. Look at yourself and your values. Do you believe in the universal "commonality" of people as well as their universal differences? Do you believe everyone has something to give, everyone has value and worth, an area of expertise and

something special to give?

Can you accept that:

1. Life is a continuous learning process for everyone?

2. Each person has the right of self-determination?

3. Each person has a right to develop his/her own potential to the fullest? Can you accept a volunteer where he/she is and help each to grow?

4. Consumers are a valuable part of planning and should be included in any plans for their welfare.

If you can accept and embrace this set of values, you are on the road to the last step in the involvement of community resources: recruitment. Once need is determined, recruit based on that need. Seek community resources only when there is a need.

When community involvement has been well planned and there is knowledgeable leadership that exercises sound principles of practice, and when the community understands its responsibility and has a firm commitment to its role, planning for and coordinating community needs with community resources is smooth and successful, and the results are mutual satisfaction for the agency, the congregation and the community.

Successful coordination of community involvement does not just happen. It requires effort, time, and a reaching out into the community. A good project requires a high degree of community involvement, but the results will be a high dividend of better service to the older person and a more effective use of human resources.

OLDER VOLUNTEERS IN PROJECTS

Voluntarism provides a ready opportunity for the older person to regain a sense of self-worth and independence, as well as an opportunity to restructure life roles and continue to make a contribution to society. Older persons will take responsibility and continue in volunteer work if it satisfies their psychological growth needs, and helps them to feel a part of the organization and the project.

1. Older volunteers need to understand what type of organization they are working for, the goals of the project, and what is expected of them. It is important to regularly keep in contact with volunteers and always let them know they are doing a good job.

2. Older volunteers find it very satisfying to "be involved" and will make a strong commitment to "helping."

   The initial motivation of older persons to give volunteer service must be encouraged and strengthened by their welcome and orientation to the project. Ongoing training and staff supervision is essential to maintain interest, satisfaction and continuity.

3. Older volunteers need the opportunity to choose different types of roles, involving differing demands on time and energy. They also like to associate with their age-related peers. Interpersonal relations among older volunteers brings them mutual support and develops new friendships.

One advantage to involving older persons in volunteer service is their availability. They have time and fewer demands on that time. They also have years of experience, a wealth of knowledge and a variety of skills. Most senior volunteers between the ages of 55 and 75, are energetic, in good physical and mental health. The majority will have a history of involvement in community, church, professional or other organizations.

When thoughtfully planned and implemented, mutual benefits of high value may be realized by older persons as well as by the project through the vehicle of older volunteer service.

Reference: Releasing the Potential of the Older Volunteer. (1976) Monograph, Older Volunteer Project. Ethel Percy Andrus Gerontology Center

ADVISORY COMMITTEE AS A RESOURCE FOR PROJECT DEVELOPMENT

Purpose. Each advisory committee has its own set of By-Laws that describes the purpose, structure and organization in specific terms.

Authority. Lines of authority and person to whom the advisory committee is responsible must be clear (usually program Director). This should be spelled out in the By-Laws.

Structure. Number of Members:Usually from 12 to 15
Length of Service:Usually one year with reappointment
Officers: Chairman, Vice Chairman, Secretary
Replacement Procedure:Nominating committee.
(These items should be clearly stated in By-laws.)

Duties. The advisory committee functions in an advisory capacity and assists the project staff in matters affecting

planning, support and significant program and personnel decisions, including the formation of basic policies for the project. Other responsibilities are:

1. To represent the entire spectrum of organizations in the community that have an interest in seniors;

2. To serve as a bridge between the project and the community, especially to help communicate information on service opportunities, recruitment of volunteers, available resources and other possible sources of community support;

3. To assist the day-to-day operation of the project by assuming responsibility for performing certain assigned operational functions. This will include, but not be limited to, the following functions: planning, evaluation, recruitment, financial support, publicity, and recognition;

4. To provide an organized system of obtaining information and advice on community interests, concerns and needs;

5. To provide advice and support to the sponsor and the project director. This may include, but is not limited to project changes, project personnel practices, community relations, volunteers' transportation, the budget, and grant applications;

6. To advise and assist in the selection or dismissal of the Project Director;

7. To provide constructive relationships with key individuals and agencies in the community;

GENERAL SUGGESTIONS

1. Know what you want an advisory committee to do for the program and ask them to do it.

2. Put in good people--clean house if necessary (and if possible). Keep them involved in exciting projects that stir their interest, but do not demand any more of their time than is proper or practical. Follow through with their ideas (if possible) and give them praise and credit.

3. Get the advisory committee involved in the planning, implementation, and evaluation of the program. Give them responsibility and respect their right to be a part of the program.

4. Establish a good system of communication including a regular meeting time and place, minutes of previous meetings mailed just before each meeting and check by phone about attendance.

5. Be sure the members understand the purpose of the program in order to advise wisely. Stress their roles (i.e., advisory, advocacy).

6. Treat them as much like the rest of the volunteers as you can (i.e., get to know them and what they need from serving, give them assignments that are significant if possible; and don't overburden those who are working full time).

7. Strive to keep emphasis on the community needs and how volunteers are being used to meet these needs.

8. Let them know they are an important part of program planning and that you need their support in order to carry out the program.

9. Use volunteers as members and give each some responsibility from which they can receive some earned acclaim.

10. Do not ever miss an advisory committee meeting if possible.

11. Listen to their advice and use it as it can be most beneficial.

12. Be honest and straightforward.

13. Have good information and challenging program ideas.

14. When planning activities or if problems arise, ask for input from members and keep them informed of the outcome.

15. Make them aware of all your goals and needs. Tell them the truth regarding the program.

16. Keep them busy.

SUGGESTIONS ON THE STRUCTURE OF AN ADVISORY COMMITTEE

1. Carefully select members with a balance of male and female, and racial representatives of agencies and community leaders.

2. Involvement of the committee is strengthened by organizing members into functioning sub-committees.

3. Give committees worthwhile projects or responsibility, and

give them time to carry them out.

4. Adoption of By-Laws provides helpful guidance.

5. Hold separate sub-committee meetings as well as "share meetings" preferably in the project office.

6. Don't have the committee too large and unwieldy.

7. Have an active hard-working Chairperson who cares for the program and the Director.

8. Use a rotating system of members.

9. Have some media representatives on the committee, not so much to generate publicity as to advise on it. They can also advise on community needs of which others may be unaware.

SUGGESTIONS ON MEETINGS

1. Have regularly scheduled meetings at the same time and place.

2. Try to make meetings productive so they will look forward to attending.

3. Prepare an intelligent and relevant agenda. Have the Chairperson come in ahead of time to work on the agenda or at least go over it with him/her before meetings.

4. Try lunch meetings. Members often don't mind going "dutch" as they usually have to eat somewhere. This sometimes works much better than either night meetings or meetings during busy hours of the day.

5. Have each meeting short, to the point and in a specified length of time (not over one hour).

6. Give each person the opportunity to express his/her ideas and points of view.

7. Don't meet too often and only when business needs to be handled. Don't waste their time.

8. Serve refreshments.

SUGGESTIONS ON WHO MAKES GOOD ADVISORY COMMITTEE MEMBERS

1. Articulate, busy people who know how to work with others and

are knowledgeable about the community and its resources.

2. People with something to offer and a desire to actually provide it.

3. People who have influence and are sympathetic with and interested in the program.

4. People already involved in responsive activities within the community.

5. Members who are "against" everything. They keep us on our toes. We work harder to show why a certain thing IS needed, and many times they do come up with answers.

6. People in lesser positions in companies and organizations (e.g., Personnel Managers).

7. Media personnel, reporters as well as editors.

8. Key people in different age groups.

9. Ministers if they are particularly interested in senior citizens.

10. Community leaders, civic club leaders, retired persons.

11. Volunteers, and sons and daughters of volunteers.

12. People with "clout" or their husbands, wives, friends.

13. Agency personnel with aging programs (e.g., nursing home directors).

14. Professionals who enjoy their work with older people (e.g., Lawyers, Doctors - but don't overwork them).

15. People in retirement.

ADVICE ON WHO MAKES BAD ADVISORY COMMITTEE MEMBERS

1. People who are all talk and do no work.

2. People who are appointed because of their names.

3. Persons regardless of age who are already overloaded with civic jobs in the community.

4. Presidents, chairpersons and legislators.

5. Former officials of government.

6. A person looking for a job.

7. People who meet to eat.

8. Retired military men.

9. Crusaders.

10. Professional volunteers (volunteer for everything and know everything).

11. Garden club or bridge club ladies.

12. Bored housewives with hangover sorority complex.

13. Unhappy, opinionated, inactive, and withdrawn people.

CHAPTER 4. PLANNING, RESEARCH AND EVALUATION

Barbara Payne, PhD and Earl D. C. Brewer, PhD

Planning for the program involves the collection of information about clergy and congregational responses: (1) to older members, (2) to older people in the local community, and (3) to agency involvement of clergy and congregational members in community programs and services for older persons. Since there has been little effort to collect such information on a state or national level, most users of this model will have to collect this information.

The task of collecting the information is the research part of the project. We recommended a state-wide mailed survey of clergy and agency staff. The questionnaire needs to be short and easy to complete. The one tested in the Georgia State Project shown in Figure 3 includes demographic items, questions about the involvement of congregations in programs for older adults, and a 32 item test of attitudes toward older persons.

The survey serves several purposes. It provides information about clergy and congregations and older persons. It can be used for promotion and recruitment when announcing forthcoming programs in an introductory letter or with a flyer about them. Finally, the opinion test becomes a part of the evaluation of the progress of the participants in the program. The collection of information and the use of the opinion test make up the research part of the project. This survey questionnaire was also developed to use with the participants. At the beginning of the first session, it provides the project director and faculty with useful information about the participants and their congregations. When this information is collected from participants in several sites it provides a summary description for a final evaluation and report.

EVALUATION

Three methods of evaluation may be used: (1) the pre-post test; (2) the informal evaluation and discussion during and at the close of the last training session and (3) an evaluation form mailed to all participants in the training six months after the completion of the course (Figure 4).

The 32 item opinion test developed by Payne and Brewer for the STM was constructed out of a study of existing scales and the development of items related to the purposes of the continuing education project. It was pre-tested with a national sample of clergy.

Figure 3.

Older Persons In Congregations and Communities

This is part of a project of the Gerontology Center dealing with clergy and older persons in ministry. This information will be tabulated by computer in a confidential manner. It will not be used in connection with your name.

Below are some statements about older persons, congregations, clergy and communities. Please read over each one and circle the number which best describes your response to it.

1 = strongly disagree; 2 = disagree; 3 = agree; 4 = strongly agree.

		sd	d	a	sa
1.	Participation in congregational activities tends to decline among older persons	1	2	3	4
2.	Most clergy need more knowledge of community assistance programs for the elderly	1	2	3	4
3.	Most of the elderly are handicapped by illness and are dependent upon public support	1	2	3	4
4.	The life expectancy of blacks at age 65 is about the same as whites	1	2	3	4
5.	Clergy have ample suggestions for meeting spiritual needs of the elderly	1	2	3	4
6.	People become more religious as they grow older	1	2	3	4
7.	The life expectancy of men at age 65 is about the same as women's	1	2	3	4
8.	The needs of older people are best met outside the congregation	1	2	3	4
9.	Most clergy need more information about the aging process	1	2	3	4
10.	The proportion of widowed is decreasing among the aged in our society	1	2	3	4

		sd	d	a	sa
11.	Congregations have a major responsibility to older people in their geographical area	1	2	3	4
12.	Most clergy know how to counsel families about relationships between generations .	1	2	3	4
13.	Most old people get set in their ways and are unable to change	1	2	3	4
14.	The government at all levels provides the social and health services needed by persons over age 65	1	2	3	4
15.	Other than worship, few congregations sponsor intergenerational activities involving all ages	1	2	3	4
16.	Most clergy feel the need for more training in aging and how to work with older persons	1	2	3	4
17.	Achievement in various artistic, creative, and scientific fields is at its highest in early life and declines continually	1	2	3	4
18.	Most congregational activities are aimed more at younger than older members	1	2	3	4
19.	Most clergy are uncomfortable with their own aging	1	2	3	4
20.	Old people have too much power in business and politics	1	2	3	4
21.	Older people get more attention and services in community groups than in congregations	1	2	3	4
22.	Most clergy have little training in the needs of older persons	1	2	3	4
23.	Most buildings of congregations are barrier-free for the handicapped members	1	2	3	4
24.	Most older persons become senile and childlike in their behavior	1	2	3	4

		sd	d	a	sa
25.	Most congregations have a higher proportion of their membership 65 years of age or older than the community population	1	2	3	4
26.	Congregations seldom work with other congregations in programs for the elderly	1	2	3	4
27.	Most clergy prefer to work with younger than older people	1	2	3	4
28.	The majority of older people no longer have sexual desires or are sexually active	1	2	3	4
29.	Most congregations have programs of home visitation for the elderly	1	2	3	4
30.	Older persons volunteer more than younger persons	1	2	3	4
31.	Most services to meet the needs of the elderly are offered in community agencies rather than in congregations .	1	2	3	4
32.	Older members are excluded from the governing body of most congregations . .	1	2	3	4

Please provide some information about your congregation and older persons.

1. Name of Congregation_____

2. Religious affiliation or denomination _____

_____

3. County _____

4. About how many total members are in the congregation?

____

5. About how many members between 50 and 65 years of age?_____

6. About how many members between 65 and 80 years of age?_____

7. About how many members between 80 and 100 years of age?_____

8. How many members 100 years or older?_____

9. Please check the approximate size of the community in which the congregation is located: (1)____rural (under 2,500); (2)____small town (2,500-10,000); (3)____city (10,000-50,000); (4)____metropolitan area (50,000-up) inner city; (5)____metropolitan area (suburban); (6)____other (write in)_____

10. Here are some activities or services which congregations may provide for older members. Obviously, no congregation would provide all of these. Please check yes or no for each item.

Activities, Services Provided by the Congregation for Older Members	yes	no
(1) Fellowship clubs	___	___
(2) Trips	___	___
(3) Arts and crafts	___	___
(4) Congregational meals	___	___
(5) Meals on wheels	___	___
(6) Counseling	___	___
(7) Ecumenical programs	___	___
(8) Prayer and worship	___	___
(9) Study groups	___	___
(10) Home visitation	___	___
(11) Barrier-free entry to buildings . . .	___	___

	yes	no
(12) Special programs honoring elderly . . .	___	___
(13) Works with community agencies for elderly	___	___
(14) Provide meeting places for AARP chapter	___	___
(15) Provide meeting places for other activities for the elderly . . .	___	___

Write in other activities:

(16)_____

(17)_____

11. Please provide some information about yourself and congregation.

(1) Your age group: (1)____under 35; (2)____35-44;

(3)____45-54; (4)____55-64; (5) ___65 and over.

(2) Gender (1)_____Male; (2) _____Female.

(3) Race (1)_____Black; (2)_____Caucasian; (3)_____Other.

(4) Check highest level of education: (1)_____High School; (2)_____College; (3)_____Seminary; (4)_____Graduate School;

(5) Have you had any formal training in gerontology? (1)_____yes; (2)_____no.

(6) Have you had any continuing education experiences dealing with the needs of older persons? (1)_____yes; (2)_____no.

(7) Would you be interested in participating in further training in this field? (1)_____yes; (2)_____no.

(8) If yes, which one of the following would you most likely participate in, if available? (check as many as apply).

(1)_____training provided by denomination.

(2)_____training provided by an ecumenical group.

(3)_____training provided by a college or seminary.

(4)_____training provided by a gerontology center.

(5)_____training provided by a state agency on aging.

(6)_____other (write in)_____

_____.

(9) Would you be interested in receiving a report on this study? (1)_____yes; (2)_____no.

(10) Your name _____

(11) Address _____

Thank you for your help. Please return in the postage-free envelope to the Project Director, Dr. Barbara Payne at:

The Gerontology Center
Georgia State University
University Plaza
Atlanta, Ga 30303-3083

Figure 4.

My Evaluation of the Certificate Program on Congregations and the Elderly

	Helpful					Most Helpful
1. Lectures	1	2	3	4	5	6
2. Discussions	1	2	3	4	5	6
3. Readings	1	2	3	4	5	6
4. Project Planning Report Sheets	1	2	3	4	5	6
5. Breaks between sessions	1	2	3	4	5	6
6. Development of project	1	2	3	4	5	6
7. Presentation of project in Augusta	1	2	3	4	5	6
8. In general, my goals were met (add other items as needed)	1	2	3	4	5	6

9. I am (1)____clergy; (2)____aging staff; (3)____lay person;(4)____other agency staff.

10. I am (1)____male; (2)____female

11. I participated in the following workshop: (1)____Atlanta; (2)____Augusta; (3)____Cornelia; (4)____Macon; (5)____Savannah; (6)____Tifton.

12. As you reflect on your workshop experience what suggestions do you have for us as we plan future continuing education events dealing with congregations and the elderly? Is there anything else (positive or negative) you would like to share with us?

(Please use the reverse side or additional sheets for your reply. Thank you very much)

It is designed to be administered as a pre and post-test to measure changes in the attitudes and knowledge of the participants in the course. Table 1 shows the pre and post scores of the participants in the Georgia project with a t test of significance. This table may be used to compare the scores of your participants.

ADMINISTRATION AND INTERPRETATION OF THE CLERGY OPINION TEST.

It is preferable to administer the test before the first session begins and again at the last session of Unit 2 instruction. Instruction to the participants includes: (1) Answer all of the statements. If uncertain, circle the answer that best expresses your opinion. (2) The test will be repeated at the last session of the program. (3) Check to be sure your name is on the test. This is important for matching your first and second tests. Your name will not be used for any other purpose. It will not appear on any reporting of the class performance. Only scores will be used.

For participants who may miss the first session, administer the instrument prior to attending a session.

SCORING

The test is scored: 1 for strongly disagree; 2 for disagree, 3 for agree; and 4 for strongly agree. About half of the items are true (+) and half are untrue (-). See Table 2.

The test was constructed so that there were eight items dealing with the congregation (numbers 1, 8, 11, 15, 18, 23, 26, 29), eight dealing with clergy (numbers 2, 5, 9, 12, 16, 19, 22, 27), eight dealing with aging (numbers 3, 6, 13, 20, 24, 28, 30, 32) and eight dealing with society (numbers 4, 7, 10, 14, 17, 21, 25, 31).

The results may be reported by the mean score of each item as in Table 2 and or by the four categories.

INTERPRETATION

The before and after scores with t tests show the areas of change. For example, in Table 1 there were only 9 items for the clergy with scores which changed enough during the course to be considered statistically significant. There were 26 for the agency staff, nearly three times as many.

Table 1.

The "Before" and "After" Mean Scores with t Test Significances for Items in Payne-Brewer Scale for Clergy and Agency Participants in Continuing Education Courses in Georgia, 1989.

Item	Means Scores					
	Clergy (n = 44)		T	Agency (n = 63)		T
	"Before"	"After"	Sig	"Before"	"After"	Sig
1	2.14	2.22	NS	1.97	2.21	S
2	3.61	3.71	S	3.40	3.67	S
(-) 3	2.18	2.25	NS	2.36	2.21	NS
(-) 4	2.39	2.28	NS	2.30	2.23	S
(-) 5	2.30	2.55	S	2.36	2.48	S
(-) 6	2.61	2.58	S	2.68	2.52	S
(-) 7	2.30	2.31	NS	2.18	2.38	S
(-) 8	2.30	2.46	NS	2.23	2.29	S
9	3.51	3.55	S	3.31	3.51	S
(-)10	2.22	2.20	S	2.44	2.25	S
11	3.55	3.55	NS	3.24	3.36	S
(-)12	2.39	2.39	NS	2.37	2.38	S
(-)13	2.37	2.37	NS	2.37	2.33	NS
(-)14	2.36	2.28	NS	2.30	2.37	NS
15	2.76	2.83	NS	2.75	2.92	S
(-)16	2.67	2.63	S	2.50	2.59	S
(-)17	2.35	2.28	NS	2.40	2.38	S
18	3.07	3.10	NS	2.96	3.19	S
19	2.79	2.96	NS	2.53	2.78	S
(-)20	2.31	2.24	NS	2.31	2.24	NS
21	2.58	2.55	S	2.55	2.68	S
22	3.05	3.05	NS	2.97	3.05	S
(-)23	2.40	2.15	S	2.21	2.34	S
(-)24	2.20	2.36	NS	2.42	2.40	NS
25	2.65	2.74	S	2.68	2.71	S
26	2.87	2.74	NS	2.71	2.81	S
27	2.92	2.90	NS	2.74	2.81	S
(-)28	2.24	2.23	NS	2.37	2.30	NS
(-)29	2.44	2.43	NS	2.52	2.48	S
30	2.71	2.77	S	2.90	2.96	S
31	2.90	2.96	NS	2.94	3.02	S
32	2.27	2.30	NS	2.09	2.23	S

This indicated that those who knew more learned more. When it was broken down by category there was a tendency for the clergy to know more about congregations and aging and the agency people to know more about aging and society. This indicates the great need for clergy to learn more about gerontology and community programs and for agency staff to learn more about congregations and aging. Higher scores by agency participants

may indicate their greater familiarity with aging concerns and issues.

An item by item review of scores shows the areas of needed information. For example Table 1 shows a mean score of 3.26 for item 2. This means that the clergy strongly agree that they need to know more about community programs for the elderly. The mean score for item 9 of 3.20 shows the strong need by the clergy for more information about the aging process. These two items alone support the need for the program you are undertaking.

Project directors or researchers who wish more technical information about the opinion test or have other questions may write to Earl Brewer or Barbara Payne at the Gerontology Center, Georgia State University, Atlanta, GA 30303.

Table 2.

Mean Scores on Payne - Brewer Scale of Attitudes Toward Older Persons in Congregations and Communities

	Item	Mean Score
1.	Participation in congregational activities tends to decline among older persons.....	2.17
2.	Most clergy need more knowledge of community assistance programs for the elderly.....	3.26
3.	Most of the elderly are handicapped by illness and are dependent upon public support.....	1.85
4.	The life expectancy of blacks at age 65 is about the same as whites.....	2.02
5.	Clergy have ample suggestions for meeting spiritual needs of the elderly.....	2.24
6.	People become more religious as they grow older.....	2.61
7.	The life expectancy of men at age 65 is about the same as women's.....	1.72
8.	The needs of older people are best met outside the congregation.....	1.85
9.	Most clergy need more information about the aging process.....	3.20
10.	The proportion of widowed is decreasing among the aged in our society.....	2.05
11.	Congregations have a major responsibility to older people in their geographical area.....	3.35
12.	Most clergy know how to counsel families about relationships between generations.....	2.09
13.	Most old people get set in their ways and are unable to change.....	2.29
14.	The government at all levels provides the social and health services needed by persons over age 65.....	1.62

15.	Other than worship, few congregations sponsor intergenerational activities involving all ages.....	2.73
16.	Most clergy feel the need for more training in aging and how to work with older persons	2.21
17.	Achievement in various artistic, creative, and scientific fields is at its highest in early life and declines continually.....	1.92
18.	Most congregational activities are aimed more at younger than older members.....	2.80
19.	Most clergy are uncomfortable with their own aging.....	2.58
20.	Old people have too much power in business and politics.....	1.90
21.	Older people get more attention and services in community groups than in congregations..	2.50
22.	Most clergy have little training in the needs of older persons.....	2.96
23.	Most buildings of congregations are barrier-free for the handicapped members.....	1.96
24.	Most older persons become senile and childlike in their behavior.....	1.80
25.	Most congregations have a higher proportion of their membership 65 years of age or older than the community population.....	2.59
26.	Congregations seldom work with other congregations in programs for the elderly.....	2.75
27.	Most clergy prefer to work with younger than older people.....	2.66
28.	The majority of older people no longer have sexual desires or are sexually active.....	1.81
29.	Most congregations have programs of home visitation for the elderly.....	2.39
30.	Older persons volunteer more than younger persons.....	2.65

31. Most services to meet the needs of the elderly are offered in community agencies rather than in congregations..... 2.78

32. Older members are excluded from the governing body of most congregations..... 1.93

SECTION II: THE CURRICULUM

The eight chapters in this section are the recommended basic content of the curriculum. Each chapter addresses a segment of the curriculum. It is not intended to be exhaustive of the subject, but it is intended to identify key issues and concepts, provide some background information, suggest some approaches to the material and recommend some resources.

The study of the processes and phenomenon of aging includes all academic disciplines and fields of professional practice. Aging is not one process, but includes the biological, social and psychological processes. Chapters 5, 6 and 7 deal with these processes. Chapter 8 examines the similarities and differences in the organizational structure and function of congregations and aging agencies; Chapter 9 explores community and congregational programing by, with and for older adults; Chapter 10 is an overview of community resources for older people and for new programing; Chapter 11 addresses issues in counseling older persons and their families; and, Chapter 12 deals with selected policy issues such as Ethics and Aging. Financing health care, intergenerational equity, employment, income, pensions and taxation are potential issues for this curriculum segment.

CHAPTER 5. THE AGING PROCESS: SOCIAL DIMENSIONS OF AGING

Barbara Payne, PhD

Aging does not take place in isolation. People age biologically and psychologically in the company of others, in a social environment with their peers or cohorts in a particular time or period of history. The study of aging encompasses the social situation which determines how persons experience physical and psychological aging as well as societal responses to an aging population.

The purpose of this section is to understand the social dimensions of aging and the meaning of changes in the age structure of society for individuals and social organizations. The following outline is intended to be helpful in organizing the vast amount of information related to the social dimensions of aging:

I. Social aging

   A. Social definitions of aging

   B. Social process of aging

      1. Social roles
      2. Socialization

II. Demographics of aging

   A. Social characteristics of the older population

      1. Profile of Older Americans (AARP Brochure)
      2. Future projections

   B. Impact of longevity on the age structure

      1. U.S. Population Pyramids: 1960-2050
      2. Age, sex and cohort differences

III. Meaning of the Aging of the Population

   A. Aging, period and cohort effects

   B. Chronological time line

IV. Suggested topics

   A. Family

      1. The older couple, late life marriages, divorce

2. Intergenerational relationships: sons, daughters, siblings, grandchildren
3. Widowhood (gender differences)
4. Living alone
5. Needs and resources (income, housing, health care, transportation)

B. Work and retirement

1. The older worker
2. Retirement process
3. Gender differences

C. Health, health care and support services

1. Wellness
2. Care givers
3. Home support services

D. Death, dying, loss and bereavement

1. Facing ones own death and losses
2. The dying role
3. Death and dying of significant others such as spouse, son, daughter, grandchild, friend, neighbor (pet)
4. Grief process and depression

E. Economics

1. Income needs and sources
2. Older consumer and new economic ventures
3. Generational equity

F. Political and governmental responses

1. Voting and political power
2. Governmental programs for older citizens

G. Religious, civic and voluntary organizations

1. Religious membership and participation
2. Civic and community organizations
3. Work or professional organizations
4. Community centers, AARP chapters, Shepherd's Centers

LEARNING GOALS FOR THE SESSION

1. Develop an understanding of the meaning of age structure changes occurring in society.

2. Identify implications of age structure changes for clergy and aging agency staff as they work with older persons and their families.

It is impossible in the 3-4 hours designated for social aging to cover all of the areas in the outline in depth. However, there are tested approaches for presenting the topics in the outline that can provide an overview and a framework for the other segments of the curriculum.

SOCIAL AGING

In the first session allocate time to the social definition of aging and to social terms that will be used throughout this presentation.

Social definitions of old age. The chronological age for defining old age varies. The most frequently used age is 65, the age of eligibility for social security. However this can be expected to change as the age for eligibility (by law) changes so that by the year 2027 it will be 67. Some organizations are using a younger age, some an older age to mark the entrance into older adulthood. For example, the American Association of Retired Persons (AARP) has lowered its age for membership to 50. An older worker is defined as 40 by the age discrimination act of 1978.

The social process of aging. Age is not a social role, but is one individual characteristic used to determine eligibility to occupy some positions (roles) in the organization of groups and to modify the expected behavior for an individual in a specific position (Atchley,1987). There are age appropriate social roles (positions), for example, a parent, spouse, driver, voter.

Socialization is the process of learning at each stage of the life course how to perform new roles, adjust to changing roles and relinquish old ones. Throughout the life course we are entering, continuing, adjusting and exiting social roles.

If there is sufficient time, the instructor may decide to spend more time on social roles and how they determine social structure.

DEMOGRAPHICS OF AGING

Population statistics and characteristics are important, but too much time can be consumed with them. It is suggested that the instructor deal with this by providing the students with copies of the current "Profile of Older Americans" and "A Portrait of

Older Minorities" published by AARP and available without cost. With these flyers in hand basic descriptive information can be cited and minority comparisons introduced. Encourage the participants to study these and keep them for reference.

A second segment on demographics focuses on the impact of aging on the societal structure, how it is changing the shape of society. Use the population pyramids shown in Figure 5 to demonstrate graphically the change as it has occurred since 1960 and is expected to change by the year 2050. This figure also introduces the concept of cohort effects. It shows the progression of the Depression, Baby Boom and Baby Bust cohorts as they move through the population.

MEANING OF THE AGING OF THE POPULATION

A third discussion introduces aging, cohort and period effects as important concepts for understanding aging behavior. Definitions and explanations of these concepts might include the following.

Aging effects. Aging effects are the changes persons experience as they grow older and include maturation and developmental changes. It also includes changes that accompany the biological aging process and the social context in which aging occurs.

Cohort effects. Cohorts are those persons born at the same time period, such as 1900-1909, 1910-1919. Members of the same cohort experience similar events at the same time in the life cycle. For example, the Depression was experienced by persons of all ages alive between 1930 and 1939; but it was experienced differently by teen age cohorts, young adult cohorts and older adults. In the 1980's as the Depression cohorts turn 65, it has been documented that they adapt more successfully to the social changes of the aging process.

Period effects. Events, physical and social changes occurring at specific time periods in the larger society are sources of age differences in behavior or attitudes. The Depression was a period effect experienced differently by each cohort. Other examples would be the attitudes about women's roles, attitudes toward retirement, events such as World Wars I and II, the Korean and Vietnam conflicts.

Figure 5. Population Pyramids

United States Population Pyramids

1960–2050

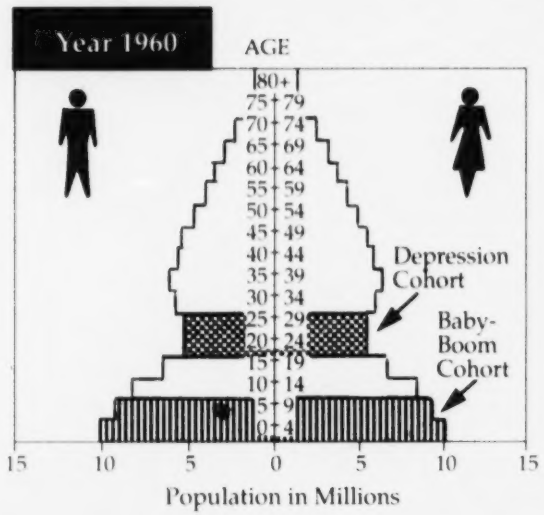
by Age and Sex

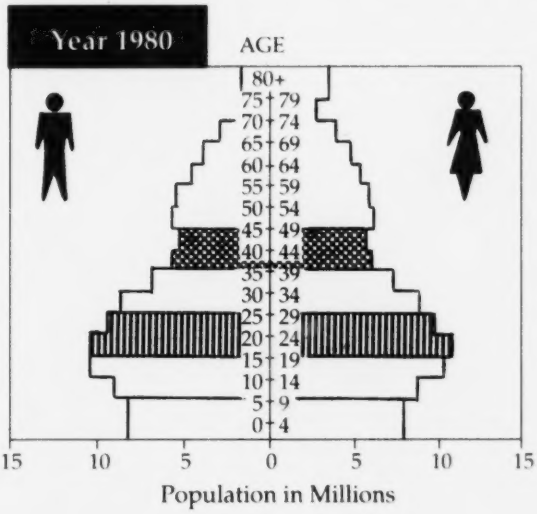
Progress of: Depression Cohort
Baby-Boom Cohort
Baby-Bust Cohort

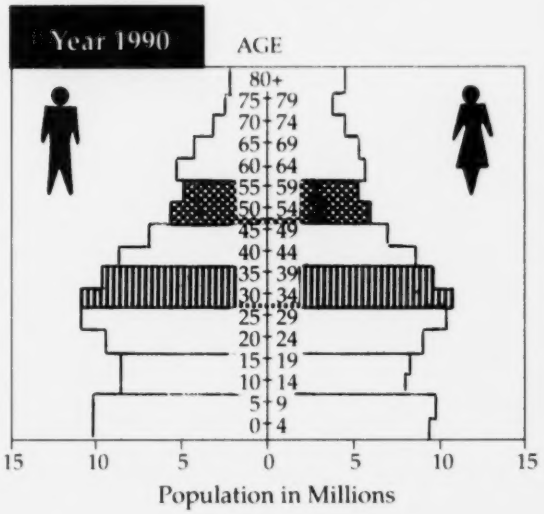
Source: "America's Baby-Boom Generation; The Fateful Bulge"

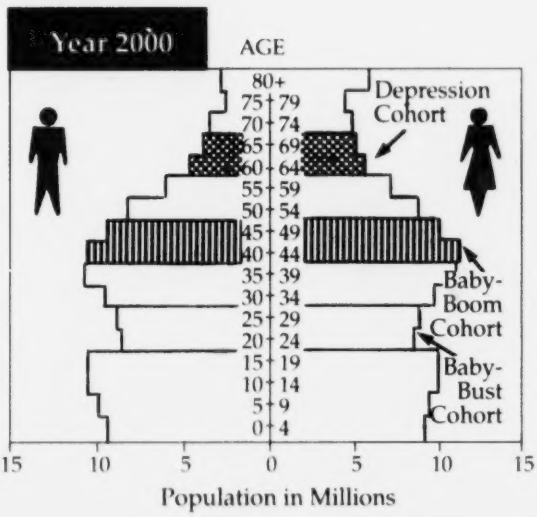
Population Bulletin 35, 1 (1980) pp. 18-19

Figure 5. Population Pyramids (con't)









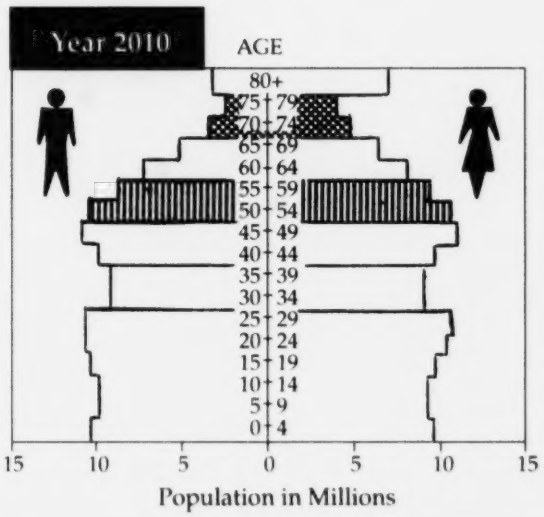
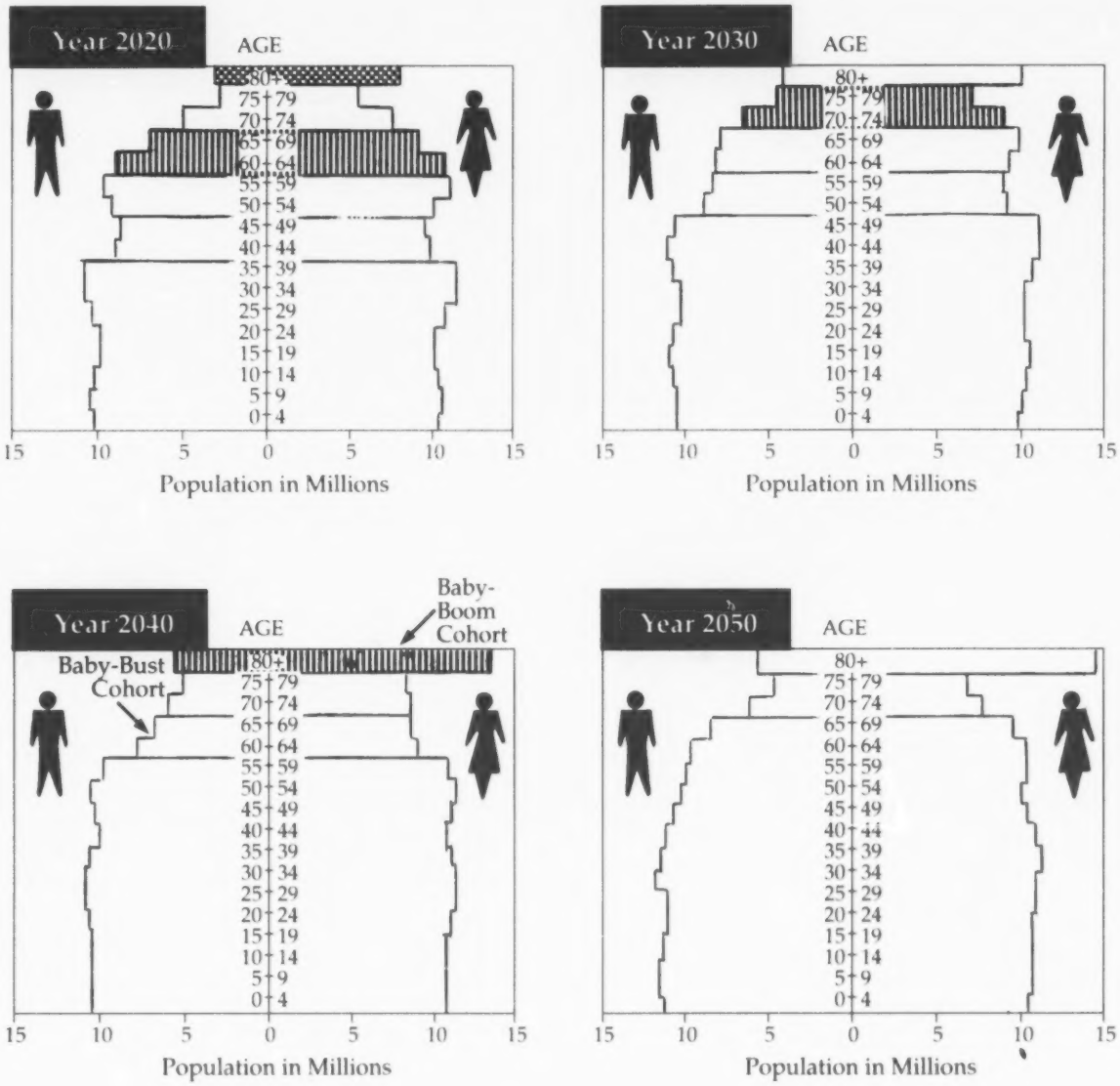


Figure 5. Population Pyramids (con't)



Depression Cohort
Persons Born
1930-1939

Baby-Boom Cohort
Persons Born
1950-1959

Baby-Bust Cohort
Persons Born
1970-1979

Compilations: 1960-1970 U.S. Bureau of the Census, *1970 U.S. Census of Population: General Population Characteristics, United States Summary*, Vol. I, PC(1)-B1, 1972, Table 52; and 1980-2050: Special unpublished tabulations prepared by Leon F. Bouvier for the Select Commission on Immigration and Refugee Policy, 1980.

[a] Includes survivors of Depression cohort.

[b] Includes survivors of baby-boom cohort.

Note: 1980-2050 projections assume a total fertility rate rising to 2.0 births per woman by 1985 and constant thereafter; life expectancy at birth rising to 72.8 years for males and 82.9 years for females by 2050; net immigration constant at 750,000 persons per year.

Aging, cohort and period effects are interrelated, but efforts to identify these contribute to our understanding of the age differences in social behavior and to our ability to predict the behavior of future cohorts of older persons.

A successful method to demonstrate the societal changes and events affecting the aging process that have occurred since 1890 is the chronological time line (see Figure 6 as a Model for discussion). Filling out the time line in discussion helps the participants understand those persons currently over the age of 65 and those who will be over 65 in the next 40 years. It is important to be reminded that all the persons who will be older adults between 1990 and the year 2040 are alive today. Studying the social changes, and cohort and period effects on the Baby Boom and Baby Bust cohorts provides a basis for planning for the future.

When using the time line, point out that those born in 1890 make up the 25,000 to 45,000 persons over 100 years of age. Willard Scott, NBC -- The Today Show, shows us 5 days a week some of them and that they are "looking good." Invite the participants to identify events and changes, in approximately chronological order, that have affected social aging and contributed to longevity. You can expect some of the following to be named:

1. Rural to urban transition;

2. Transportation (trains, automobiles, airplanes);

3. Communications (telegraph, radio, telephone, television, computers, satellites, facsimile machines;

4. Medical technology (disease and infection control, birth control, transplants, surgical procedures); family life (smaller and smaller families, drop in infant mortality, divorce, longer and shorter marriages, two, three, four and five generation families);

5. Armed conflicts (World Wars I and II, Korean and Vietnam conflicts);

6. Economic factors (Depression, pensions);

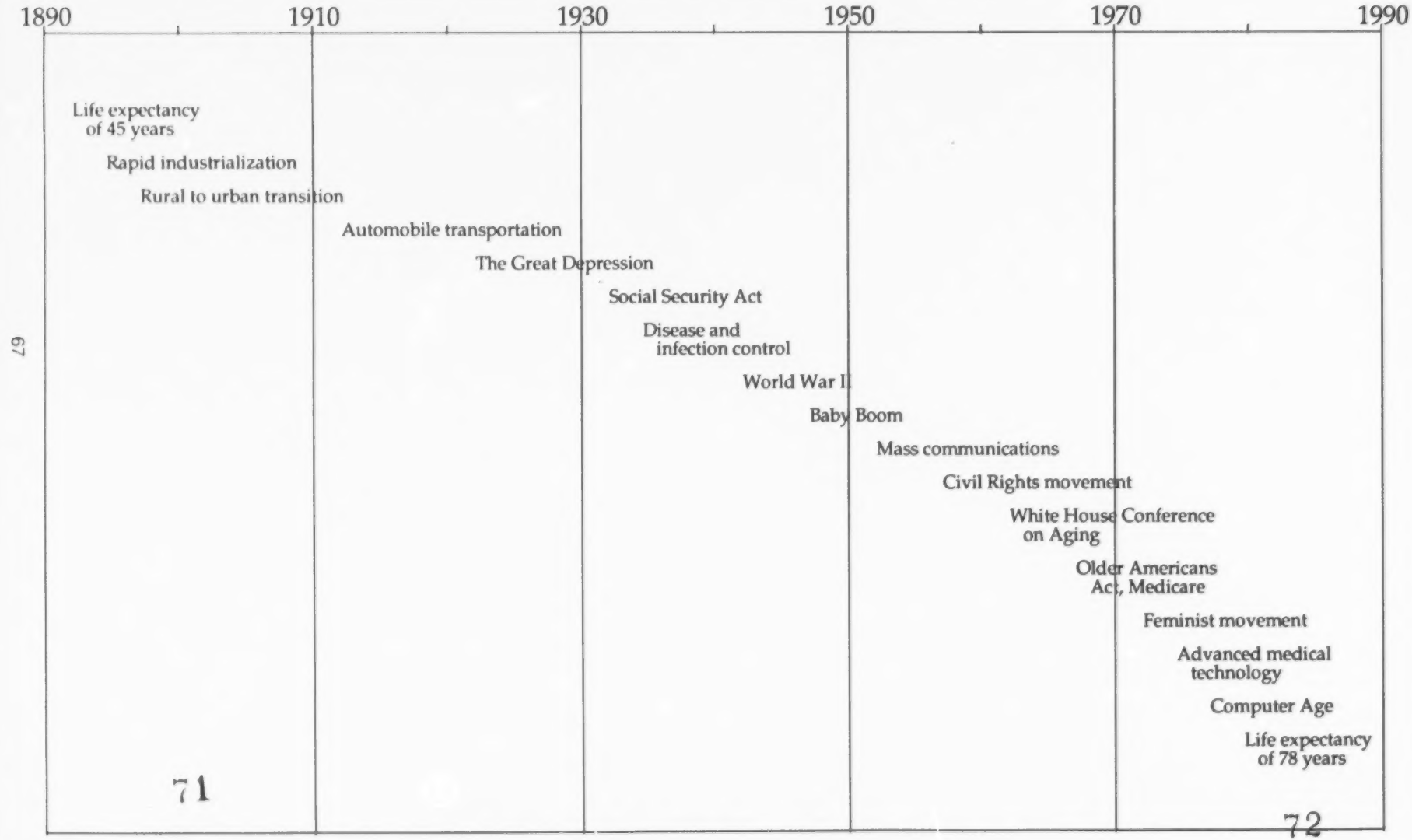
7. Work force factors (retirement, early retirement trend, shorter work weeks, paid vacations, health benefits, women entering the work place);

8. Electricity;

9. Public education (including college);

Figure 6.

PERIOD EFFECTS ON THE EXPERIENCE OF AGING: A MODEL FOR DISCUSSION OF EVENTS AND SOCIAL CHANGES



10. Public policy (Social Security legislation 1935, Older Americans Act 1965, Age Discrimination Act 1978, Catastrophic Health Care 1988);

11. Food (changes in production and processing of foods, importing of foods, fast food chains);

12. Civil rights movement;

13. Women's movement.

This list is not exhaustive but is suggestive of the kinds of input to elicit from participants.

At any point in the listing of events and changes, the instructor could elaborate and introduce information that might appear under the selected topics. For example, the Social Security entry could be used for a short lecture on retirement income and the issues of generational equity; the entry of the Age Discrimination Act could provide an opportunity to discuss the older worker and the age of retirement.

This exercise has proven to be a popular and productive session. It sets the stage for all that follows. Course participants told us that it demonstrated for them the adaptive power of older persons who lived through these changes and helped them understand the differences among older persons.

SUGGESTED TOPICS

The final session in this curriculum segment provides the time to focus on one topic in the outline. It is recommended that this topic be "The Family and Intergenerational Relationships" because clergy report that this topic represents their area of greatest need for understanding and skill development to meet the counseling needs of their members. Aging agency staff deal with families of older persons on a daily basis.

The instructor may plan this session by using IV. A of the outline, or organize it around the issues of "you and your aging parents", "you and your aging children", role reversal and interdependence or issues such as divorce, and late life marriage.

This topic lends itself to the use of family vignettes such as those found in the film, My Mother, My Father: Caring for Aging Parents, or situations which the instructor introduces or ones generated by the group. If you choose to ask the group for situations, this could be done by dividing the participants into groups of three to five and assigning an area to develop such as divorce among older persons or other family members;

grandparenting; mother-daughter and mother-son relationships; father-daughter and father-son relationships; sibling relationships; marriage and remarriage; and residential relocation.

The number of groups and issues need to be determined by the time allotted for this session. The generated situations become the basis for teaching about these topics and for discussion with the participants.

RESOURCES

Atchley, R. C. (1987). Aging continuity and change (3rd ed). Belmont, GA: Wadsworth.

Dychtwald, Ken, & Fowler, Joe (1989). Age wave. Los Angeles: Jeremy P. Tarcher.

Silverstone, B. & Hyman, H.K. (1976). You and your aging parents. New York: Pantheon.

Kingson, E.R., Hirshorn, B.A. & Cornman, J.M. (1986). Ties that bind, Washington, DC: Seven Locks Press.

Heschel, A.J. (1981). The older person and the family in the perspective of Jewish tradition. In C. LeFevre & P. LeFevre, Aging and the human spirit. Chicago: Exploration Press.

CHAPTER 6. THE AGING PROCESS: BIOLOGICAL DIMENSIONS OF AGING

The focus of the Biological Dimensions of the Aging Process should provide an overview of the normal biological changes with aging. There are many such changes occurring in every biological system and some of them create not only physical problems, but also conditions that affect the whole psychosocial response pattern of the older person. For this reason, the limitation of time necessitates an overview session that includes the most significant areas of change that affect the health and functionality of persons as they age. The subject area is extensive and selection of topics must be made relative to resource persons available and content most helpful to clergy and agency staff as they work with older persons.

GENERALLY, AN OVERVIEW OF THE BIOLOGICAL DIMENSIONS OF NORMAL AGING INCLUDES:

1. Theories of biological aging;
2. Aging changes in selected systems of the body, such as:
    a. Myths and facts of aging;
    b. The musculoskeletal system;
    c. The cardiovascular system;
    d. The respiratory system;
    e. The neurological system;
    f. The major sensory systems;
    g. The immunological system;
    h. The renal system;
    i. The reproductive system;
3. Functional health and wellness;
4. Community health systems;
5. Health care issues.

SUGGESTED LEARNING GOALS FOR THIS AREA COULD INCLUDE:

1. Understanding basic biological changes with age and their relationship to behavior;

2. Understanding the impact of sensory impairments such as vision, hearing and speech on older persons and the implications for congregations and agencies;

3. Understanding the significance of physical therapy for rehabilitation in chronic illness and the role congregations and agencies can play;

4. Identify health care issues of older persons and the implications for programming.

RESOURCES

An outline for dealing with a selected overview of the dimensions of normal aging follows. The outline is based on a presentation made at the 1989 Atlanta training site by Dr. Jean Mistretta, Chairman and Professor of Community Health Nursing, School of Nursing, Georgia State University. In securing persons for this curriculum section, it would be helpful to seek a biology professor, medical doctor, or community health nurse with research or experience in geriatric medicine.

For additional presentations to highlight special biological dimensions of aging or areas of concern, three curriculum outlines or resource papers have been included. The first is a curriculum outline on Blindness and Visual Impairment by Dr. Saul Freedman of the American Foundation for the Blind. A list of regional offices from which to obtained resource persons can be secured from the American Foundation for the Blind National Headquarters, 15 West 16th Street, New York, NY, 10011.

The second resource piece is on Aging and Communication. Dr. Forrest Umberger, Professor of Special Education, Georgia State University, has highlighted important issues and resources for this area. Resource persons for this area may be found in schools with special education programs focused on older persons or among therapists registered with local hospitals.

The third resource piece is on the growing area of health care issues presented by Dr. Louise Duncan, retired, Dean of the School of Nursing, Georgia State University. Exploration of this area moves the course participants quickly into practical application of the biological

dimensions based on their experience and daily contact with older persons.

If time permits, additional content sessions could be developed around presentations by an orthopedist, a physical therapist or similar persons who deal with chronic physical problems of older persons. A session concerning practical health care issues would be profitable.

ADDITIONAL SUGGESTED RESOURCE

Lazarus, Lawrence W., Ed., (1988). Essentials of geriatric psychiatry: a guide for health professionals. New York: Springer.

OVERVIEW OF THE BIOLOGICAL DIMENSIONS OF AGING

Jean Mistretta, PhD

I. Selected biological theories of aging

Over the years aging has been seen by many as a time of redundancy when older persons are no longer needed. Everyone ages uniquely, therefore biological aging is different from person to person. Generally we see over the life span:

* Women have greater longevity;
* Genes are programmed and each of us has hereditary traits that are influenced by environmental factors.

Theories of aging have to conform to three criteria:

* Universal: What happens occurs for everyone in the species;
* Intrinsic: What happens to your outside body happens to your organs as well;
* Must be a gradual aging phenomenon: The process occurs gradually.

A. The Immunological Theory of aging says that the body seems to react to itself, and an auto-immune condition similar to lupus develops in which the body attacks its own cells and aging results.

B. The Free Radical Theory states that as our body cells change, divide and multiply, free radicals are formed. That is, cells floating around in the body get in touch with oxygen or in a body deficient in some vitamins (A and E especially), attach themselves to normal cells and cause the changes that we call normal aging.

C. The Cross-Link Theory is the overriding theory of biological aging today. Cross bonding of cells occurs causing conditions we interpret as normal aging. For example, externally we see skin sagging and wrinkling; internally the muscles get stiffer and less flexible, such as the heart muscle, and other organs are similarly affected.

II. Myths and facts of the biology of aging

A. Some myths of health and aging:

1. Everyone will be senile and lose memory;

2. Persons are no longer productive;

3. Persons are no longer sexual;

4. Old age is a disease;

5. When you go to the doctor, be passive and expect medications.

These myths are not true. For example, talking to the doctor is important and many older people don't know how. The current cohort was not encouraged to voice their concerns with a doctor and many feel they don't know what or how to ask questions, don't know terminology and would not understand the answers. However, this can be overcome with education.

B. Some facts about health and aging:

1. Pathological signs and symptoms do not present the same way in older persons as in younger ones. For example, a silent heart attack may appear to be only a chest pain. Pain anxiety in the older person isn't evidenced the same way as in a younger person. The pain threshold for older adults is different, that is, it is much higher for older persons. They don't experience pain as much.

2. Mental illness may appear with organic symptoms and somatic or bodily disease may appear as a mental disturbance. One common mental illness in the older age group is depression. Depression is difficult to diagnose because the symptoms of withdrawal, fatigue and weight loss can be symptoms of so many physical and psychological conditions.

III. Evaluation of the total person is critical.

Many social, cultural, psychological and physical conditions influence the health status of the elderly. For example, an older person may stop coming to a clinic or quit taking medicines because they don't understand the importance of following the health regimen. Also, treatments and medications are expensive. Other reasons for non-adherence include lack of transportation or the inability to read and write or understand the forms required.

Many forms have been designed for the assessment of psychosocial information about the person. This is very important to clergy and agency staff for referrals. Some hospitals with geriatric services provide base-line health data for evaluation of older persons but this is usually not covered by insurance unless designated for a specific pathology.

Research in aging shows there are some bodily changes. Collagen elastin in the body is reduced. Muscle tissue loses moisture which causes some evidence of aging. There are cardiovascular and respiratory changes. It is unclear whether this is part of normal aging or pathological.

There is not a lot of longitudinal data on health changes in older people. We do have the Framingham, Mass. study in which subjects have been followed for 50 years. The first correlation we see is evidence connecting smoking with the incidence of strokes. Usually researchers look at cross-sectional studies and this compounds the problem of understanding health issues.

IV. Systems of the body

A. Head, neck and skin

Skin. Generally there is a loss of moisture in tissues, resulting in wrinkles and changes in skin tone. Spotty pigmentation of areas of the skin most exposed to the sun occurs. Retin-A, the new miracle drug for wrinkles, is really effective on sun exposed areas but not for other causes of wrinkling. Extremities are cooler because of less fat and decreased circulation.

Skin shows an increase in moles, red and blue spots as older people tend to bruise more easily. This is due to capillary fragility which may be due to nutrition and lack of iron. Older people often eat less meat and often develop anemia due to dietary habits.

Hair. It becomes duller and hair loss begins to occur on the scalp and all over the body for both men and women.

Nails. They grow more slowly and tend to be brittle.

Eyes. They generally change after age 40.

Nearsightedness or presbycusis is common. As we grow older, the pupils of the eyes often become unequal due to difficulty with accommodation to light. Older people need three times as much light to read as younger persons. The lens becomes more opaque and there is a yellowing of the sclera of the eye. There are other

causes of the yellowing such as liver problems, medications, and megadoses of vitamin A. Lens opacity causes light to scatter making glare a problem for older adults. Consensual lighting works best for older persons. Some older people have difficulty with peripheral vision. They tend to have a straight line or tunnel vision effect. This may lead to problems with night driving. Arcus senilus is a little grey line around the pupil, but it does not represent a problem, just aging. Lid Lag or drooping lower eye lids cause loss of moisture and dryness because moisture does not get to the right part of the eye. Excess tearing can occur. This can and sometimes must be corrected surgically.

Nose. It tends to lengthen and become sharper as we age.

Smell. The sense of smell decreases with aging. There is a change in the taste buds which affects the sense of smell. Older people need more spices, especially salt, to taste food. Older people should be encouraged to use lemon juice and other salt substitutes.

Ears. Tinnitus or ringing in the ears is not normal in aging. There is a decreased acuity for high pitched sounds.

Mouth. The condition of the teeth and gums is important. The gag reflex becomes more sluggish. Dentures may not fit properly because of gum atrophy or weight loss.

B. Musculoskeletal system

There is a loosening of the cartilage in joints from the collagen elastin problem which results in less flexibility than during the younger years. Exercise is very important. However, older persons should start slowly and not overtax their systems. They do not have the physical reserves they had when younger and need a much longer warm-up and cool-down period. In other words, they cannot abruptly start or stop activity without consequences.

It takes a longer time to increase the pulse rate when older. In younger persons the pulse goes back to normal rates when activity stops. However this is not true in older persons. It may take 15-30 minutes for a return to normal, due to normal aging or medications. Even when walking briskly, do not stop abruptly but walk slowly for awhile.

Osteoporosis is a loss of calcium from the bone which causes a decrease in bone density. Post menopausal women are especially susceptible. Unexplained fractures may be one symptom. The biggest loss of calcium occurs in the first year of menopause. A diet rich in calcium may be helpful if estrogen is also prescribed.

C. Cardiovascular system

Everything in this system is usually all right for older persons unless they are taxed in some way. For example, illness or emotional crisis may cause cardiovascular symptoms without previous symptoms. The blood pressure should be checked regularly, and in both arms, while sitting, standing and lying. There can be drastic changes in blood pressure from lying or sitting to standing which result in dizziness or postural hypotension. The veins in the legs pool blood and hold it, decreasing the volume to the heart or head. This may happen when getting up during the night, and falls can occur. It is recommended that older adults with this problem sit on the side of the bed for a while before standing. There is no one, standard normal blood pressure although we use 120/80 for younger persons. In older persons abnormal pressure would be over 140 over 90.

Medication for blood pressure in older people can sometimes be a problem. When blood pressure is high the blood vessels are stiff and the heart pumps against a stiff aorta, thus increasing pressure. A secondary problem is seen in the distention of the left ventricle (the pumping part of the heart).

The heart has four chambers, and as the person ages, the heart becomes stiffer. The outside wall becomes thicker and the pressure inside all four chambers of the heart is much greater. That means less blood is pumped out. Serious heart pain is right over the sternum, but in the older person pain can also be in the jaw, shoulder or left arm without any chest pain. Nausea, paleness and perspiring heavily can be indications of heart attack also.

The heart valves are stiffer and therefore it i. not uncommon for older persons to have a murmur, an extra heart beat, or galloping beats caused by left ventricular thickening and extra pumping action. Part of the heart works very hard and that area often enlarges.

Congestive heart failure is failure of the heart as an effective pump. It actually wears out over time. Fluid backs up into the lungs. Cross-bonding of tissues causes thickening and means extra work for the heart. When this happens, the heart does not pump well, and fluid backs up into the respiratory system. Coughing is often the first symptom. Digitalis to slow the heart and a diuretic like lasix can help deal with the situation.

The leading cause of death in older persons is heart disease, but in chronic conditions, congestive heart failure is a major cause of death. This condition can also affect the renal system as there is 50 percent less blood flow to the kidneys and the filtration function slows down.

Risk factors for cardiovascular disease include:

a. High fat diet;
b. Cholesterol over 200;
c. Lack of exercise;
d. Hypertension.

D. Respiratory system

Generally this system stays unaffected as aging occurs. There is an increase in anterior/posterior diameter to allow the lungs to expand as much as possible. There is an increase in the dead space, that is, air that is not exchanged at all but stays in the lungs. There is a decrease in the hairs in the nose that help get rid of nasal secretions. Coughing is not effective for this purpose. Except for these conditions, the respiratory system ages well. Smoking is the biggest indicator of lung condition. The transfer of oxygen in the lungs is not as efficient, whether one has smoked or not.

E. Neurological system

A person's I.Q. does not significantly increase or decrease after age 50. Short and long-term memory stays intact for normal functioning.

There is sensory impairment in older persons. There is decreased pain perception and decreased reaction to heat and cold. There is a general decrease in response to touch. There is usually a hearing loss of high frequency tones.

F. Nutrition

The greatest vitamin deficiencies in older persons are vitamins A, B, and C. We normally get these in a balanced diet of green leafy vegetables and meat. Many older people, especially living alone, do not eat well and tend to eat prepared foods higher in calories and lower in nutrition.

V. Categories of functional health status

A. Breathing: Shortness of breath, pain on coughing, wheezing, bloody sputum.

B. Circulation: Heart pain, heaviness, episodes of rapid heartbeat, skipped beats, dizziness, blackouts.

Vessels: Varicose veins, cold hands or feet, "charley horses," leg pains (walking/at rest).

C. Communication: Any problems making oneself understood by others.

D. Eating: Appetite, enjoyment of food, diet or dieting, weight, chewing problems.

Cooking: Skill, enjoyment, resources;

Shopping: Transportation, skill, frequency, finances;

Eating Patterns: Meals per day, typical foods;

Locale: Home or restaurant, alone or with others.

E. Elimination: Bowels: Frequency, time, concerns, associated problems, medications.

Urine: Frequency, urgency, pain, leaking, up at night.

F. Grooming: Importance to person, capabilities, frustration.

G. Mobility/Safety: Pattern and location of activities, gait, accidents, balance, weakness, dizziness, stiffness, pain, status of feet and shoes, appropriate clothing available.

H. Senses: Vision, hearing, use of glasses or hearing aid; tactile; sensory stimulation -- desired or available.

I. Sleep: Sleep patterns -- night/naps, number of pillows, medications, times up at night.

J. Social/Emotional/Cognitive: Memory problems, difficulties in comprehending, slowed response and processing time; satisfaction with social life, barriers, use of time, difficult times.

The number one goal for older persons is to maintain independence. The best way to get this is by offering support in neighborhoods. Blood pressure clinics, exercise groups and such can make the difference in whether people can stay at home.

In terms of assessing resources in the community, we look for availability, accessibility, and eligibility. There are many gaps in services regarding community care for the older person. Try to fit the needs of the older persons to the services available.

SUMMARY: OLDER PERSON'S HEALTH STATUS

For the older person, symptoms are just as serious as for younger persons, but often they are exhibited in a very different way so that they do not look as serious.

Older people are very sensitive to medication and what we see as a neurological or cardiovascular problem could be a reaction to a medication.

The problem of evaluating the whole person is critical for older persons. Knowing the social, financial and environment situation of a person can be essential to some diagnoses and treatments chosen for older persons.

RESOURCES

Health

Bamwell, L. (1983, Oct.). Use of life history in pattern identification and health promotion; ANS, 7 (1), 37.

Brown, J.S. McCreedy, M. (1986, Dec.). The Hall elderly: health behavior and its correlates, ANS, 9 (4), 317.

Eliopoulas, C. (1987). Gerontological Nursing. Philadelphia: Lippincott.

Engle, V. (1984, Oct.). Newman's conceptual framework and the measurement of older adults' health; ANS, 7(1), 24.

Harper, D. (1984, April). Application of Orem's theoretical constructs to self-care medication behaviors in the elderly; ANS, 6 (3), 29.

Johnson, F., Cloyd, C.S. and Wer, J. (1982, April). Life satisfaction of poor urban black aged; ANS, 4 (3), 27.

Reed, P. (1983, October). Implication of the life-span developmental framework for well-being in adulthood and aging; ANS, 6 (1), 18.

EENT

Mahoney, D. (1987, September - October). One simple solution to hearing impairment; Geriatric Nursing, 8 (5), 242.

The whole issue of Geriatric Nursing September/October, 1986. Vol. 7, (5) On oral care and assessment.

GI

Stewart, D. (1986, July, August). What is Angiodysplasia? Geriatric Nursing, 7 (4), 180.

Mental Health

Antaine, M. (et al). (1986, July/August). Measuring improvement in patients with dementia. Geriatric Nursing. 7 (4), 185.

Brady, P. (1987, June). Labeling confusion in the elderly. Journal of Geriatric Nursing, 13(6), 29.

Gomez, G.S. & Gomez E. (1987). November/December) Delirium. Geriatric Nursing, 8 (6), 330.

Kim, K. (1986, September). Response time and the health care learning of elderly patients. Research in Nursing and Health, 9 (3), 233.

Mace, N. (1987, June). Facets of dementia. Journal of Geriatric Nursing, 13(6), 33.

Ronsman, K. (1988, January/February). Pseudodementia. Geriatric Nursing, 9 (1), 50.

Sexuality

MacPherson, K. (1985, July). Osteoporosis and menopause: a feminist analysis of the social construction of a syndrome. ANS, 7 (4), 11.

Travis, S. (1987, June). Older adults' sexuality and remarriage. Journal of Geriatric Nursing, 13(6), 8.

Osteoporosis

Chesnut, C., Cummings, S., Drinkwater, B, & Johnston, C. (1988). New options in osteoporosis. Patient Care, January 15.

VISION IMPAIRMENT

Vision impairment is a major concern of older people. There are normal changes in the eye with age: 1.) the lens begins to yellow, 2.) the oscilliary muscle loses tone, 3.) pupil size decreases, and 4.) the number of retinal cells decreases. This means that as one grows older there may be some problems of visual accommodation. However, not all persons develop visual impairments as they age, that is, develop vision loss that interferes with functional performance of one or more activities of daily life.

In the United States, 1.4 million persons are severely visually impaired but not all are legally blind. More than half of all legally blind persons (500,000) are over age 65 while 25% of the elderly population report some difficulty seeing. Forty-three percent of all nursing home residents are visually impaired (344,000). By the year 2000, there will be 272,000 to 367,000 legally blind people over age 65 and 1,756,000 severely visually impaired older persons.

It is known that the majority of blind persons are women because women tend to live longer than men. Minority group persons are more susceptible to blindness with 71 out of every 1,000 non-white persons being blind. Sixty-one percent of all persons who are visually impaired have multiple handicaps, such as, an additional sensory impairment, arthritis, diabetes, or heart condition.

Source: National Center for Health Statistics
U.S. Department of Health and Human Services
3700 East-West Highway, Hyattsville, MD 20782

One half of all blindness in older persons can be prevented with proper vision care. The four major causes of blindness in older people are 1. senile cataracts, 2. macular degeneration, 3. diabetic retinopathy, and 4. glaucoma. It is also known that 80% of older persons with vision loss retain some usable vision ability. Persons with low vision problems can receive many kinds of assistance today.

Identification of persons with visual impairments or low vision problems is a major concern nationally. Most older persons accommodate to vision changes as they age. Achieving acceptance of these losses and willingness to receive assistance on the part of older persons is a major challenge to clergy and agency staff.

A CURRICULUM OUTLINE FOR CLERGY AND THE AGING NETWORK
BLINDNESS AND VISION IMPAIRMENT

Saul Freedman, PhD.

I. Overview of blindness and vision impairment

A. Demographics

1. Recent hard data
2. Projections
3. Reasons for undercount in aging

Resource materials: Current data from National Center for Health Statistics and from American Foundation for the Blind.

B. Causes of vision loss

1. Macular degeneration
2. Glaucoma
3. Cataracts
4. Diabetic retinopathy

Resource materials: See A.F.B. pamphlets regarding above topics.

C. Definitions

1. Legal blindness - partial sight - useful sight
2. Total blindness
3. Severe visual impairment

Resource materials: See A.F.B. Low Vision Questions and Answers

D. History of services

1. Private agencies for the blind
2. State agencies for the blind
3. Veterans services for the blind
4. Generic and categorical services
5. Community and agency based services

II. Analysis of what is lost through blindness and vision impairment

A. Physical integrity

This is the loss of totality or wholeness as a person--

an usually quick, shattering trip from "in-group" to "out-group."

B. Confidence in the remaining senses

The onset of blindness or vision impairment creates within the person a loss of confidence in the remaining senses. It is a myth to expect the other senses to compensate for the loss of sight.

C. Reality contact with the environment

This anxiety producing loss comes about because of the dominant sensory intake role of sight.

D. Visual background

This is the loss of monotony relief provided by the living, moving, interacting, colorful background in which things are observed.

E. Light security

This loss is about public equating of blindness and darkness which is not only false but damaging as it wrongly assigns the morbid connotations of darkness to blindness.

F. Mobility

The loss of the ability to get about with grace, ease, and safety.

G. Things of daily living (TDL)

The sledge hammer blow of no longer being able to do the hundreds of simple things that daily need doing.

H. Written word

This is the loss of the active and passive use of graphics.

I. Spoken communication

This is the loss not only of active oral communication but also of our extensive use of body language and inflection.

J. Information progress

This loss is in not being able to keep up with the news,

standing still while the world goes by.

K. Visual perception of the beautiful

This is the loss of the visual embrace of the aesthetic -- a most serious loss to some people.

L. Visual perception of the pleasurable

This is the loss of the visual intake of something the blinded person formerly found pleasing.

M. Recreation

This is the loss of one's ability to do those things which refresh and reinvigorate us, when we want to do them.

N. Job opportunity

For the many of the 40% or so of those blinded adults under age 65 these are most serious losses. Blindness can have real and imagined impact on vocational plans.

O. Financial security

This loss involves more than loss of money security. It concerns expenses incident to blindness, over and above the expected expenses.

P. Personal independence

This loss concerns the personality one brings to his/her blindness, and balanced feelings of dependence independence.

Q. Social adequacy

This is the loss of acceptance by one's friends and family -- the loss of dignity. This loss is often forced upon the blinded person by the friendly and sympathetic people who surround him.

R. Obscurity

This is the loss of the ability to get lost; to be little or anonymous. The blinded person becomes public property. He loses individuality.

S. Self-Esteem

This loss involves the loss of objective self-evaluation

and subjective self-image.

T. Total personality organization

This is the cumulative loss resulting from this series of shattering blows to a whole life pattern.

Resource Materials:

Carroll, Thomas J. (1961). Blindness: What it is, What it Does, and How to Live with It. Boston: Little Brown and Co.

Freedman, Saul - Aging and Blindness; The Father Carroll Approach (paper available from American Foundation for the Blind).

III. Negative reactions to vision loss in aging

A. The Individual. There may be an impact upon religiosity: "My Father, if it be possible let this chalice pass from me." "Why me?" The person may pray each night for restoration. There may be displacement of feelings of anger, rejection, isolation, abandonment.

B. The Family. Reactions may be similar to the individual. There may also be experiences of ignorance, desire to see, desire for independence.

C. The Community. There may be use of the concept of punishment for sin, use of the word affliction.

D. The Professional. Concepts of ageism stereotypes and disability may be intertwined.

Resource materials:

Freedman, Saul and Inkster, Douglas E. "The Impact of Blindness in the Aging Process" (paper available from The American Foundation for the Blind).

IV. Recommendations for actions

A. Recognize changes in vision

B. Clergy as catalyst

C. Access community resources

D. Clergy as advocate

E. Modify the environment

F. Maintain accessibility to the house of worship

G. Counsel older person to feel "forgiven" or to deal with feelings of guilt about blindness.

V. Implications for clergy -- congregations, agencies

Resource materials:

The American Foundation for The Blind, 15 W. 16th St., New York, NY., 10011.

Aging and vision. AFB & AARP.

Hilton, Jamie C. Caring for blind and visually impaired residents in a nursing home.

Orr, Alberta. The elderly visually impaired patient: What home care providers should know.

Scott, Judy & Henderson, Doris. Techniques for assisting older blind persons

Van Son, Allene. (1985). Diabetes, vision impairment, and blindness.

AFB Catalog - Products for people with vision problems

Bibles and Scripture in special media - reprint compilation of several catalogs.

U.S. Consumer Product Safety Commission. (January, 1985). Safety for older consumers. (available through AFB).

AGING AND COMMUNICATION

Forrest Umberger, PhD.

"Much of the success or failure of any communicative interaction results from the perceptions and expectations of the partners." (Barbara B. Shadden)

It is the purpose of this section to consider some issues that are likely sources of misconceptions about communication with the elderly. In order to more effectively communicate with the elderly we need to be aware of the physiological changes that occur as a function of aging and how such changes affect the way in which the elderly process language, hear and speak. Knowledge of these processes will enable the service provider to make appropriate adjustments to insure that the elderly are afforded maximum opportunity to communicate.

Woelfel (1976) describes communication as a kind of energy. He suggests that cutting off persons from the receiving of information transmitted through communication effectively isolates those persons from activity. Inactivity in turn breeds major health problems (mental and physical) and can speed the aging process artificially.

The remainder of this section will address those issues deemed pertinent in developing a curriculum for training others in the effects of aging on communication. The areas of focus will include:

1. The Effects of Aging on Hearing;

2. The Effects of Aging on Speech and Language;

3. Communication Disorders in the Elderly.

It is impossible to avoid all instances of jargon in the areas of speech, language, and hearing. When such terms are not understood, even in context, the reader is directed to the following text:

Nicolosi, L., Harryman, E., and Kresheck, J. (1989). Terminology of communication disorders speech-language-hearing, Third Edition, Williams and Wilkins.

THE EFFECTS OF AGING ON HEARING

Rationale. A National Health Interview Survey established that 24% of persons between 65 and 74 years of age have a hearing impairment. The prevalence of hearing impairment for those 75

years of age and older is about 39%. It is estimated that by the year 2050 the elderly will constitute 59% of the hearing impaired population. Given these data it is not surprising to learn that hearing loss is one of the most common health impairments among elderly Americans. One cannot overlook the contribution and necessity of an intact hearing mechanism to the communication process. Considering the increasing prevalence of hearing disorders in the elderly one can readily appreciate the importance of understanding the nature of hearing and how such knowledge can be employed in developing strategies for overcoming this deficit in the communication process.

The kind of questions we need to answer are:

1. How does the ear work?

2. How is hearing measured?

3. What are the major kinds of hearing loss and what kinds of hearing deficits are associated with aging?

4. How do we communicate with an older individual who has a hearing loss?

Topics and Resources

THE EFFECTS OF AGING ON HEARING

(The numbers following each of the topics corresponds to the reference numbers which are listed under the section entitled "References.")

A. Anatomy and physiology of the hearing mechanism
   (5) pp. 245-292
   (8) pp. 146-166

B. Audiogram
   (8) pp. 178-179

C. Conductive and sensorineural hearing loss
   (7) pp. 415-434

D. Hearing losses associated with the aging process
   (6) pp. 137-157

E. Tips for communicating with individuals with hearing impairments
   (3) 383-407

THE EFFECTS OF AGING ON SPEECH AND LANGUAGE

Rationale. During aging, changes in anatomy and physiology such as muscle atrophy, reduction in muscle strength and reduction in elasticity affect respiration, phonation and resonation. Such changes are sufficient to alter an individual's voice. Understanding how the voice and speech mechanisms change with advancing age will enable us to avoid making unrealistic demands on the elderly with regards to speaking. For example we might avoid a speaking environment with an ambient noise level greater than the elderly speaker is able to overcome by raising his/her voice.

Similarly, elderly individuals experience changes in their linguistic abilities as reflected in the parameters of phonology, morphology, syntax, semantics and pragmatics. Awareness of how these parameters are altered with age will sensitize us, for example, to older individuals' need for additional time to process complex linguistic structures and increased response time needs.

Topics and Resources

THE EFFECTS OF AGING ON SPEECH AND LANGUAGE

A. Anatomy and physiology of the articulatory mechanism
   (5) pp. 119-169

B. Anatomy and physiology of the vocal mechanism
   (5) pp. 63-117
   (1) pp. 25-40

C. Anatomy and physiology of the respiratory mechanism
   (5) pp. 17-64

D. Anatomical and physiological changes in the speech mechanism as a function of aging
   (6) pp. 162-165

E. Acoustic characteristics of older adult speech

   1. Respiratory related vocal changes
   2. Phonatory alterations
   3. Resonance changes
   4. Articulatory modifications
      (6) pp. 162-169

F. Changes in language comprehension and expression as a function of aging

   1. Phonological parameter

2. Morphological parameter
3. Syntactic parameter
4. Pragmatic parameter
(6) pp. 167-177

COMMUNICATION DISORDERS IN THE ELDERLY

Rationale. The most common forms of communication impairment associated with aging are stroke-related communication disorders, communication disorders in dementia, motor speech disorders, and laryngectomy. While the above disorders are best left to the care of a certified speech-language pathologist, it behooves all service providers to familiarize themselves with these disorders for a couple of reasons. First, it is not uncommon for a service provider to notice some of the first symptoms of a communication disorder. With a basic understanding of the various disorders the service provider will be in a better position to make an appropriate referral. Secondly, understanding the major characteristics of each of these disorders will enable the service provider tho employ the most effective modification when communicating with an elderly individual exhibiting one of the following communication disorders.

Topics and Resources

COMMUNICATION DISORDERS IN THE ELDERLY

A. Stroke related communication disorders
(7) pp. 561-589
(6) pp. 197-204

B. Communication disorders in dementia
(6) pp. 204-210

C. Motor speech disorders
(6) pp. 210, 211

D. Laryngectomy
(6) pp. 211, 214
(2) Chap. 4, Chap. 5, Chap. 11,

References

1. Boone, D.R. (1988). The voice and voice therapy. (4th ed.). Englewood Cliffs, NJ: Prentice Hall.

2. Edels, Y. (1983). Laryngectomy diagnosis to rehabilitation.

Rockville, MD: Aspen.

3. Hull, R. (1982). Technique for aural rehabilitation treatment for elderly clients. In R. Hull, (Ed.). Rehabilitation Audiology. New York: Grune & Stratton.

4. Nicolosi, L., Harryman, E. and Kresheck, J. (1989). Terminology of communication disorders speech-language-hearing. (3rd ed.). Baltimore: Williams & Wilkins

5. Perkins, W. H. and Kent, R. D. (1986). Functional anatomy of speech, language and hearing - A primer. San Diego: College-Hill Press.

6. Shadden, B. (1988) Communication behavior and aging: A sourcebook for clinicians. Baltimore: Williams & Wilkins.

7. Shames, G. H. and Wiig, E. H. (1986). Human communication disorders, (2nd ed.). Columbus, OH: Merrill.

8. Skinner, P. H. and Shelton, R. L. (1985) Speech, language and hearing normal processes and disorders. (2nd ed.). New York: Wiley.

HEALTH CARE ISSUES

Louise B. Duncan, RN, PhD

Important health care issues:

* Individual health status and chronicity of disease(s);
* Cost of health care and quality of health care;
* Availability of health care;
* Selective ethical issues.

Demographics affecting health care issues:

* The average 65 year old will live approximately two more decades;

* From 1988 until 2000, total Georgia population will increase by more than 40%, while the 65 + age group will increase at twice the rate and the 80 + age group will increase by 140%;

* Currently there are 732,000 older citizens in Georgia; by year 2000, this number will increase to more than one million;

* By 2000, 35% of the average Georgia doctors' practice will be older persons.

Rationale: Population trends are important as they emphasize the magnitude of the health care issues of the elderly and the need for planning now.

Source: Georgia Council on Aging.

I. Individual health status and chronicity of disease(s)

A. Importance of life styles to health: How one lives, what one eats, how one exercises, ones attitude toward life, all impact on individual health. (See Figure 7 "Your Lifestyle Profile").

B. Precursors to illness or "poor" health are many.

1. Overweight -- this emphasizes the importance of nutrition, calories, salt, cholesterol

2. Inactivity -- exercise important for everyone; stretching, walking, chair exercise; planned exercise program stressed

Figure 7.

Your Lifestyle Profile

Please check the space that applies to you.

Exercise

1. How much physical effort do you expend during the workday? Mostly

   _____ (0) Heavy physical or walking

   _____ (1) Housework

   _____ (3) Desk work

2. Do you participate in physical activities, such as skiing, golf, jogging, swimming, lawn mowing?

   _____ (1) Daily

   _____ (3) Weekly

   _____ (5) Seldom

3. Do you participate in a vigorous exercise program?

   _____ (1) Three times weekly

   _____ (3) Weekly

   _____ (5) Seldom

4. Do you walk or jog daily?

   _____ (1) More than a mile

   _____ (3) Less than a mile

   _____ (5) None

5. How many stairs do you climb each day?

   _____ (1) More than 10

   _____ (3) Less than 10

Nutrition

1. Are you overweight?
   _____ (1) No
   _____ (3) Five to 19 pounds overweight
   _____ (5) Twenty or more pounds overweight

2. Do you eat a variety of foods--something from each food group? (meats, milk and milk products, bread and cereals, fruits and vegetables)
   _____ (1) Each day
   _____ (3) Three times weekly

Alcohol

1. How many bottles (12 oz.) of beer do you drink each week?
   _____ (1) 0-7
   _____ (3) 8-15
   _____ (5) 16 or more

2. How many drinks (hard liquor) do you have per week?
   _____ (1) 0-7
   _____ (3) 8-15
   _____ (5) 16 or more

3. What is the total number of drinks per week, including beer, liquor, and wine, do you have?
   _____ (1) 0-7
   _____ (3) 8-15
   _____ (5) 16 or more

Drugs

1. Do you take drugs illegally?
   _____ (1) No
   _____ (5) Yes

2. Do you consume alcoholic beverages together with certain drugs (tranquilizers, barbiturates, antihistamines or illegal drugs)?

_____ (1) No

_____ (5) Yes

3. Do you use "pain-killers" excessively?

_____ (1) No

_____ (5) Yes

Tobacco

1. How many cigarettes do you smoke per day?

_____ (1) None

_____ (3) Less than 10

_____ (5) Ten or more

2. How many cigars do you smoke per day?

_____ (1) None

_____ (3) Less than 10

_____ (5) Ten or more

3. How many pipe tobacco pouches do you use per week?

_____ (1) None

_____ (3) Less than two

_____ (5) Two or more

Personal Health

1. Do you experience periods of depression?

_____ (1) Seldom

_____ (3) Occasionally

_____ (5) Frequently

2. Does anxiety interfere with your daily activities?

_____ (1) Seldom

_____ (3) Occasionally

_____ (5) Frequently

3. Do you get enough satisfying sleep?

_____ (1) Yes

_____ (3) No

4. Are you aware of the causes and dangers of sexually transmitted diseases?

_____ (1) Yes

_____ (3) No

5. Do you get a Pap test routinely?

_____ (1) Yes

_____ (3) Occasionally

_____ (5) None

6. Do you practice breast self-examination?

_____ (1) Monthly

_____ (3) Occasionally

7. Do you brush and floss daily?

_____ (1) Yes

_____ (3) Frequently

_____ (5) Occasionally

Road Safety

1. Do you exceed the speed limit?

_____ (1) No

_____ (3) By 10 mph +

_____ (5) By 20 mph +

2. Do you wear a seatbelt?

_____ (1) Always

_____ (3) Occasionally

_____ (5) Never

3. Do you ever drive under the influence of alcohol?

_____ (1) Never

_____ (5) Occasionally

General

1. How many hours (average) do you watch TV per day?

_____ (1) 0 to 1

_____ (3) 2 to 4

_____ (5) More than 4

2. Are you familiar with first aid procedures?

_____ (1) Yes

_____ (3) No

3. Do you smoke in bed?

_____ (1) No

_____ (3) Occasionally

_____ (5) Yes

Count up your score; the number in parenthesis following the response that applies to you, is your score for that question -- total these.

How to Calculate your Score:

1. Score below 45 - EXCELLENT

"Excellent" indicates that you have a commendable lifestyle based on sensible habits and a good awareness of personal health. Keep up the good work.

2. Score 46 - 55 - GOOD

You have a sound grasp of basic health principles. Only one to ten points separate you from the elite. With a minimum of change you can develop an excellent lifestyle pattern. Make the effort to move up to "excellent" and stay there.

3. Score 56 - 65 - RISKY

You are taking unnecessary risks with your health. Several of your life-style habits are based on unwise personal choices which should be changed if potential health problems are to be avoided. Look at your test again. Start your improvements with the places you lost points.

4. Score 66 and over - HAZARDOUS

A "hazardous" rating indicates a high risk lifestyle. Either you have little personal awareness of good health habits, or you are choosing to ignore them. This is a danger zone--but even hazardous lifestyles can be changed and potential health problems avoided. Go over your test carefully and start making those improvements right now.

From:

Operation Lifestyle
Office of Health Education and Training
Division of Physical Health
DHR, Atlanta, Georgia

3. Smoking -- importance of clean air, decrease in pollutants, and passive smoking

4. Stress -- importance of coping skills; a survivor vs a defeatist attitude

5. Age -- only precursor not controlled by the individual's behavior

C. Chronic health problems are widespread among older individuals.

1. 86% experience chronic health problems

2. 95% of these are able to live alone in the community

3. 81% of this 95% require no assistance; 19% require some community service

D. Older individuals do not have just one health problem; they usually have 2 to 3 or more.

E. Many of the health problems are related to the aging process, although not directly caused by it.

F. Typical chronic health problems include:

1. Cardiovascular diseases, i.e. Coronary artery disease, hypertension, stroke, congestive heart failure, myocardial information

2. Diabetes mellitus (Type II, non-insulin dependent)

3. Central nervous system pathology: Alzheimers' disease, Parkinsons' disease, Multiple Ickrasis

4. Osteoporosis and osteoarthritis

5. Chronic lung disease, i.e. emphysema, asthma

6. Cataracts

7. Hearing loss

8. Emotional problems and suicide, i.e. loneliness, depression, confusion, lack of social stimulation

G. Increase in the number of chronic diseases results in other related health issues

1. More medications

2. More doctor visits

3. More hospitalization

4. Decreased independence or increased dependence

5. Poor nutrition

6. Less activity, fewer social contacts

Many of these factors result in increased health care costs.

Rationale: Chronicity and the number of health problems, as well as related factors, impact on the independent/dependent status of the individual; health status has a financial impact as "poor" health requires more services, drugs, doctor visits. Maintaining the individual's independence and providing necessary services in the home are financially prudent; health status and happiness are directly related.

Sources:

(1) Georgia Council on Aging

(2) Geriatric Nursing published by American Journal of Nursing Co.

(3) American Journal of Nursing

(4) Ehersall, P. & Hess, P. (1985). Toward Healthy Aging. C.V. Mosby.

(5) Hogstil, M. (1985). Nursing Care of the older adult. John, Wiley & Sons.

(6) Stilwall, E. (1980). Readings in gerontological nursing. Charles S. Slack.

II. Cost of health care

Governor Harris, in his 1989 address to the General Assembly, emphasized the need to contain health costs in Georgia. He proposed more community based treatment centers for the elderly. He proposed an $81 million budget increase for DHR; this would boost the Human Resources budget to over 965 million--or an increase of 32% in only 3 years: $186,195 for community care for elderly; $300,000 for 6 new Alzheimers' programs; continuation of over $1 million to implement nursing home provisions of the 1986 Omnibus Budget Act.

A. Health care costs continue to soar.

1. Many office visits are not necessary and persons should be encouraged to use physicians who accept Medicare.

2. There is a continuing increase in cost of drugs; encourage use of generic drugs when available.

3. Be an informed client on use and results of diagnostic tests; question tests which require radiation and question frequency of these; be sure an understood consent form has been signed for invasive procedures.

4. Hospitalization costs have increased with hospitalization for frail elderly, elderly with chronic diseases, and those over-medicated from prescription drugs.

5. Diagnostic related group (DRG) determination by Medicare limits time in acute care hospitals but has increased acute levels of care for patients in nursing homes, personal care homes, and private residences.

6. Older people are often exploited by health insurance companies; there is a need for adequate inservice programs that are financially feasible for all.

7. Medicare does not cover all health care costs; when the Social Security check increases due to the cost of living allowance, medicare also increases and that generally erases the increase.

B. The Catastrophic Coverage Act of 1988 is controversial (and may be repealed).

1. There would be an increase in medicare cost of 43.8% in 3 years.

   a. In 1987 medicare cost was $17.90/mo.
   b. In 1988 medicare cost was $24.80/mo.
   c. In 1989 medicare cost was $31.90/mo.
   d. Of this increase for 1988, $3.10 would be for Part B and $4.00 for the catastrophic cost component.

2. Some selected components of this act are as follows:

   a. There is unlimited hospitalization for approved cost after the individual has paid a single annual deductible. (1989)
   b. There are 150 days of care per calendar year in a medicare certified skilled nursing facility. (1989)
   c. There is unlimited hospice care, but recertification is required. (1989)
   d. There is home health care available up to six days per week for as long as prescribed by the doctor. (1990)
   e. Physician and other out-patient services are increased but have several limitations.(1990)
   f. There is respite care up to 80 hours per year. (1990)
   g. A mammogram will cost $50.00. (1990)
   h. There will be graduated payment for designated drugs. (1990-1993)

3. There are some concerns about the Catastrophic Coverage Act.

   a. It does not cover long-term or custodial care.
   b. Medicare costs of $4.00 per month in 1989 will increase to $10.20 in 1993.
   c. A supplemental premium or surcharge on tax liability is to be paid on federal income tax (1989):

      1989 - $22.50 (single person) for each $150.00 paid;
      1991 - $39.00 (single person) for each 150.00 paid;
      1993 - $42.00 (single person) for each $150.00 paid.
      The cost is doubled if both in a couple are medicare eligible.

   d. The elderly will be paying for anyone who qualifies for catastrophic health insurance even though that group will not be paying into the fund, for example, Aids patients.

Rationale for health care costs and coverage. Informed social agency workers can assist patients/clients in selecting, implementing, and evaluating health care. If all (including patients/clients) are knowledgeable of the health care system, then relevant questions can be asked and appropriate action(s) taken.

Sources:

(1) Guide to Health Insurance for People with Medicare, Consumer Information Center, P.O. Box 100, Pueblo, CO 81002.

(2) American Nurse - Publication of the American Nurses Association.

(3) American Journal of Nursing, Publication American Journal of Nursing Co.

(4) Geriatric Nursing, publication of A. J. Co.

(5) AARP publications

III. Quality of Health Care

A. Problems related to Nursing homes.

1. There is lack of training for nursing assistants; there is inadequate staff.

2. Low salaries are paid to professional nursing staff, therefore there is inadequate R.N. staff in these institutions.

3. Attitudes of nursing personnel toward the elderly often result in mistreatment.

4. The staff lack knowledge of the aging process.

5. Lack of sanitation in some nursing homes creates serious situations.

6. So many homes are having to depend on medicare funds only and these are inadequate.

7. Long-term care is recognized as a need, but who will pay first?

8. Elder abuse and neglect is found in many nursing homes, especially if families are unable to visit on a regular or frequent schedule.

B. "Well" elderly need health and social services too.

1. Significant statistics indicate:

* 51% over 65 live in their home with a spouse;

* 26% over 65 live in their own home (mostly females);
* 18% over 65 live with other family or friends;
* 5% over 65 live in nursing facilities.

2. Some need assistance with activities of daily living.

3. Some need assistance with transportation and shopping.

4. Some need supervision of home therapies and follow-up on taking medications.

5. If older people can be maintained at home, they are healthier and happier and their health care costs are less.

C. A survey in the American Nurse shows that RNs would change long term care.

1. Return to nursing judgments; RNs should make the decisions.

2. Decrease the amount of drugs given to the patients (drug holidays have been shown to be effective).

3. Most persons who are confused have memories and emotions that must be handled with sensitivity and individuality; gerontological nurse specialists are a must in these homes.

4. Increase medicare and medicaid rates; qualified personnel must be paid a salary commensurate with their professional preparation.

5. RNs are needed throughout the 24 hour period, not just one RN for an entire nursing home.

6. Attitudes toward long-term care must be changed.

7. Reduce the "mountain" of paper work to free time for patients.

D. Many physicians will not take elderly patients; many who do will not take the necessary time with them to explain treatment, diagnostic tests and test results, and other important information.

E. Many medical schools do not include sufficient theory and practice in gerontology and geriatrics.

F. The elderly are a captive group for "quackery" and for exploitation.

G. Cost of drugs and problems related to health and drugs are increasing.

1. There is a tremendous mark-up on trade-name drugs; encourage use of generic drugs when available.

2. Suggest the person shop around; the cost of drugs will vary from store to store.

3. When new drugs are ordered, have part of the prescription filled; if an allergy to the drug develops, the drug cannot be returned; if all of the prescription is needed, the remainder of the prescription can be filled.

4. To save money, older people will save drugs to take later if necessary; they will share drugs; they will alter dosage so it will last longer; they will take drugs only when they feel its needed and not as ordered.

5. Elderly patients will not question the doctor about side effects or compatibility of drugs with others prescribed.

6. Many older persons are taking more prescription drugs than they need and over-medication and drug interactions result.

   a. 5% to 10% are over-medicated with prescription drugs.
   b. one-third of confused and forgetful patients are over-medicated.
   c. 25% to 30% of hospitalizations are due to over medication by prescribed drugs.

Rationale: Quality of health care is a concern for every citizen. Stricter guidelines for quality of care and enforcement of these guidelines must be mandated. Improvement in the quality of health care for other persons will not be attained until more health professionals, especially RNs prepared in gerontology, are directing the care at the bedside. Quality of care is everybody's responsibility, but it begins with the health professionals and other ancillary personnel.

Sources: See listing for II.

IV. Availability of health care

A. Attitudes of health professionals, especially the physicians, often make the patient feel powerless.

B. Many physicians will not take elderly patients and many others will not accept medicare assignment.

C. Often the care is available, but the quality is in question due to attitudes of the health care workers, time spent with the patient, lack of written instructions or no time provided for the patient to ask questions.

D. The "working poor," who have limited incomes and no health insurance, have limited or no health care.

E. There is a need for community health centers operated by clinical nurse specialists and nurse practitioners to screen, monitor and deliver health care. These centers should be the entry into the health care system and would make referrals to physicians when indicated.

F. Acute care hospitals provide care for the elderly but often they must be discharged early because of DRG regulations.

G. Health care resources exist: Day care centers, personal care homes, nursing and long-term care homes, acute care hospitals, respite care facilities.

H. An important health care issue is the training of personnel, attitudes of the personnel and competence of the professional staff; these factors will result in improved care for the older patient.

Rationale: If life is considered precious and if we revive life, we will not only be cognizant of the care provided the elderly but we will also demand quality care; respect for life is not yet passe.

Sources: See listing for II

V. Selected ethical issues

A. Informed consent is now Georgia Law, but it is limited.

B. Elder abuse and neglect is growing, but the Council on Elder Abuse and Neglect can assist.

1. The purpose of the council is information and referral, education, and outreach.

2. For information call (404) 377-0701

C. Living Wills and continued use of life support systems are at issue.

D. Lack of concern and care for those living in poverty has ethical implications.

E. Homeless people among our aging population becomes an important issue.

F. Is health care a right or a privilege? Is there a hierarchy of those who are entitled to health care?

G. Should organ transplants be available for older patients?

Rationale: These are issues with no easy answers, but involve decisions that must be dealt with daily.

Sources:

(1) Georgia Law regarding informed consent and Living Wills.

(2) Department of Human Resources regarding quality of care for the elderly in nursing homes.

CHAPTER 7. THE AGING PROCESS: PSYCHOLOGICAL DIMENSIONS OF AGING

The Psychology of Aging covers a very extensive body of knowledge. The focus of this curriculum session should be on normal aging, examining long held societal myths and stereotypes of mental functioning as a way to remove invalid views of aging.

The dimensions of normal aging generally include:

1. Sensory processes or the means through which we experience the internal and external world; e.g., seeing, hearing, tasting, smelling (Corso, 1981).

2. Cognitive changes, or the areas of thinking, intelligence, learning abilities, problem solving, memory functions, and psychomotor performance;

3. Personality changes and development, or the stability vs. change of personality characteristics, coping mechanisms and development that can occur with age;

4. Coping with stress, losses, relationship difficulties with which counseling can assist older persons.

RESOURCES

An outline for dealing with selected curriculum areas in the Psychology of Aging follows this introduction.

ADDITIONAL SUGGESTED RESOURCES:

Atchley, Robert C. (1987) Aging: Continuity and Change (2nd ed.). Belmont, CA: Wadsworth. (suggested course text)

Corso, J. F. (1981) Aging Sensory Systems and Perceptions. New York: Praeger.

Lazarus, Lawrence W., (Ed.). (1988) Essentials of Geriatric Psychiatry: A Guide for Health Professionals. New York: Springer.

Sensory processes: The Sixth Sense with Arlene Francis
A 16mm film or videotape, National Council on Aging, 600 Maryland Avenue, S.W. West Wing 100
Washington, D.C. 20024

An additional session on abnormal dimensions of aging should be planned concerning various mental dysfunctions, such as,

depression, Alzheimer's disease and related dementias, organic brain syndrome, and other mental disorders [see LaRue, A., Dessonville, C. & Jarvik, J. (1985). Aging and mental disorders. In J. E. Birren & K. W. Schaie (Eds.). Handbook of the Psychology of Aging. N.Y.: Van Nostrand Reinhold.]. It is suggested that professional persons who deal with these problems be engaged for the session, for example, a psychotherapist who deals with depression in older adults, a psychologist who handles the session on normal aging, and staff of the Alzheimer's and Related Disorders Association (ADRDA).

PSYCHOLOGICAL DIMENSIONS OF NORMAL AGING

Angeline Benham, PhD

We all hold some myths and stereotypes about older people which are not valid. The Law of Variability, in the Psychology of Aging, states that there is more variability within the age group of older persons than between young, middle age and older persons. One can find a young 65-year-old whose physical and mental abilities match or surpass those in the young adult category.

There is a great body of research from which to draw in the Psychology of Aging. Most cited here comes from the hard science tradition.

I. Cognitive changes

A. Questions and issues

1. How will thinking change from adulthood to old age?

2. Will changes in thinking occur in power, in the ability to think, in the kinds of imagery or fantasy we experience?

3. Will there be strong differences in the way we solve problems?

4. Is there a big change in "metacognition", "how we know how we know" or "think about how we think?"

5. Will growing older mean reduction in the ability to think well, reason well and arrive at decisions for ourselves?

6. Will it be more difficult or take longer to learn new material?

7. Will growing older mean the attainment of wisdom, or at least attainment of good judgement and better common sense than we have experienced in the past?

Many of these questions have not been answered in the literature. However, they give us an idea of what needs to be explored in this area.

B. Three primary ways of studying cognition in older adulthood

1. Psychometric studies

In 1958, Wechsler, who devised one of the most used I.Q. tests said that we reach maturity of intellectual functioning at age 25 and decline thereafter.

Research in the 1970's and 1980's gives us a different picture. Not only was there new research but a look at how old research was conducted. As a result, a number of statistical artifacts were removed. For example, a 1953 study by Lehman showed that there was a peak of creativity in the lives of geniuses, in their 20's or 30's, and then there was a steep decline so that by age 70 there was only minimal creative ability. However, when the study was reinvestigated by Dennis in 1966, he found that the study included persons like Mozart who died at age 35. The artifacts were removed and divisions were made between types of creativity.

The results showed:

a. Artistic creativity peaked in the 40's then declined (probably due to physical reasons such as arthritis in hands, use of the body in ballet);

b. Scientific creativity peaked in the 40's with the level of productivity much the same to age 60 then a slow decline in the 70's (probably because one's knowledge base continues to build with age);

c. Creativity in the humanities showed a great rate of productivity throughout the years even into the 70's.

In 1974, Baltes and Schaie discovered that intellectual decline in old age is largely a myth. Other researchers (e.g. Horn, 1978) discovered two types of intelligence with differing patterns of change in old age.

Fluid Intelligence is that intelligence heavily based on physiology. Speed is a component of this type of intelligence, and older persons tend to be slower than younger persons. Not only is there slowing of motor functions, there is a slowing of some brain activities. Central nervous system processing seems to occur more slowly, especially if the task for the older person is a novel one. This fluid intelligence requires the ability to see new relationships when engaging in novel intellectual tasks, therefore research which involves these kinds of tasks shows decline.

However, the other type of intelligence, crystallized intelligence, is intelligence that refers to accumulated knowledge including vocabulary, one's store of general knowledge and facts about the world. For the typical person, this type of intelligence increases with age.

When both types of intelligence are taken together there is little difference in intellectual functioning as one ages because persons learn to compensate for lack of speed as they become more efficient in their areas of expertise. Many researchers have concluded that there is no decline in general intellectual functioning until the 70's for the typical person, and there may not be any decline even at that age.

The phrase "use it or lose it" applies to mental expertise as well as physical. Studies completed by Baltes at the Max Planck Institute in Germany clearly show that people who stay active in their areas of expertise retain their productivity and competence. Studies completed by Salthouse at Georgia Institute of Technology have found that typists, for example, who continue to type for many years have greater speed competence than younger typists. Although an older person might not perform as well in novel areas, they are likely to out perform younger persons in an area of expertise.

2. Memory and aging studies

In memory tests involving recognition of items, intellectual functioning generally is high. Recall type tests show decline in functioning. These tests tend to indicate:

a. Familiarity and practice with the items being tested contributes to good performance by older persons.

b. Pacing oneself in taking the test equalizes performance between younger and older persons. If older persons are rushed or have a time limit they make more errors than younger persons, but adequate time contributes to good performance.

c. Organizing the material on a test makes a difference. Research indicates older people sort items with fewer categories than younger persons and therefore do recall as well, in general. They fail to organize material in

the same way that young people do (Hartley, Harker & Walsh, 1980). Older persons tend to know strategies that are effective for some types of tasks, but these may not be the strategies needed for a particular test.

d. Age differences in memory and thinking. show differences probably are due to the amount of attention that can be brought to bear on a task. Younger people tend to do well because their bodies are healthy and they have more energy and attention to give to research tasks. If older persons tend to be tired, not in good health, or medicated, it is difficult for them to bring sufficient energy and attention to research tasks.

3. Contextual studies

These studies grew out of the ideas of Piaget concerning concrete, formal and abstract learning in younger persons. Piaget felt that children were bound to concrete thinking from ages 7 to 11; but during this period they begin to understand that things are not always the same as they appeared to be. Several researchers concluded that older people regressed to a similar childhood state where they were not able to engage in abstract thinking. However, contextual research studies indicate that this is not the case. Older persons do not regress but rather they move to post-formal thinking. (Arlin, 1983; Labouvie - Vief, 1985).

C. Post-formal thinking

Many researchers have found that post-formal thinking is contextual thinking, not just concrete thinking. For example, in discussion with older persons about an issue or opinion, they may respond: "I just don't know what to tell you, your situation is so different from mine." In other words, older persons operate out of specific contexts rather than being simplistic or rigid in their thinking. They refuse to over generalize; hence they have been accused of being concrete, rather than abstract in their thinking.

Another aspect of post-formal thinking found among older persons is that of raising questions. Instead of responding as though they have all the answers, they propose a question based on extensive knowledge of their areas of expertise.

In 1985 studies of wisdom, Benham and others have found older and middle aged persons were less likely to feel they had attained wisdom than were younger persons. Older persons were more likely to raise questions and be less dogmatic. In summary, post-formal thinking looks at the process in which one is engaged and draws conclusions limited to these contexts, or asks questions.

D. Summary comments on research

1. Biases are found in research. Many institutions and researchers depend upon research subjects who are very active, healthy and able to participate in research. There are also sex biases in that I.Q. tests confirm that females are better at verbal tests and males are better at spatial tests. Research may reflect a positive bias regarding aging because of the subject pool utilized, and it may reflect gender bias. More females than males may fill the subject pools.

2. Cross-sectional studies are ones that measure people of different age groups "right now", at one point in time, then generalize to all age groups. These cross-sectional studies generally give a negative bias to aging, indicating more decline than is true.

3. Longitudinal studies are ones that follow a cohort (persons born at the same time) through their lives. These tend to give a positive bias about aging. Persons who live longer tend to be healthier and better educated. For these reasons they tend to exhibit better functioning than would appear in cross-sectional studies. Those who are best endowed continue to reflect these advantages in old age.

4. In summary, regarding intellectual functioning, older persons generally find methods of compensation in their areas of expertise or special knowledge, use adaptation through contextual thinking and have high intellectual functioning in tasks with which they are familiar.

II. Personality changes

Personality is that rather consistent set of thoughts, feelings and behavior patterns that guide the organization of experience in the direction of new growth. (Definition of

personality from Barbara Newman in 1982 Review of Literature in Handbook of Developmental Psychology.)

A. Personality change in adulthood according to research findings.

1. From research on objective personality tests which measure traits (e.g., California Personality Inventory, Guilford Temperament Scale) and look at changes in scores and profiles over a lifetime; and from both cross-sectional and longitudinal research, we can draw some conclusions.

2. Conclusions on personality change when looking at personality inventories (tests): The best prediction for successful adaptation is prior adaptation through the life course. If one has gone through other life stages successfully one is most apt to go through old age successfully. Therefore, we find stable personality characteristics. For example, if one expresses satisfaction or well-being early in life, they are likely to say the same in old age even though they have encountered hardships through the life course. One's ability to adjust, to experience a sense of well being and security is likely to stay the same. Basic temperament is the same through the life span (Costa & McCrae, 1984); however, the ways in which temperament is expressed may show large changes.

B. Erik Erikson's theory and especially his interpretation of the Berkeley Longitudinal Study (of babies born 1928-1929) and extensive interview information from parents of those babies (Erikson, Erikson and Kivnick, 1986).

According to Erikson, older persons are engaged, through one or a series of crisis experiences, in introspection which tends to balance their despair with an ego integrity that results in hope. Changes in personality are brought about by asynchronies or "gaps" between personal competencies and cultural demands. The balancing struggle can be positive or negative. To illustrate from a younger age group, the young in our culture have sexual ability or competence but there is not an adequate provision for it because our culture does not provide sufficient opportunity to support and care for the babies.

The psychological context for personality development includes: the historical period in which one lives; economic factors, family and work roles, the attitudes held by one's society about one's age group; personal

talents, intelligence, motives and expressions. All contribute to the pattern of adult growth.

Change is brought about by the struggle one has balancing personal competencies and cultural demands. It is influenced by everything in one's personality extant at any one time and the historical point at which one lives out one's life. This is positive in that struggle or crisis provides the opportunity for growth and change.

C. This provides some evidence that massive personality change or reorganization can be achieved in old age. Research indicates that personality reorganization can be achieved through three avenues:

1. Through an extreme change in environment. For example, relocation when a person is sick and vulnerable can be a negative experience. However, a positive experience can result from an extreme environment change made while the person is in good health. The change can bring on a positive reorganization of personality.

2. Through life review. Butler's Life Review Process (1980) with or without an audience, assists a person to look back over his/her life, make sense of it and derive meaning from it. This review involves discovery of what one's life has meant to others, to one's self, and what it will mean in the future. Life review is best carried on with an audience of one very good listener. A person can move from unhappiness to happiness or from happiness to greater happiness through this process of review.

3. Through psychotherapy or intensive counseling. Several principles of counseling for older persons, especially for the current cohort can be recommended on the basis of studies.

   a. It must be presented as education or group support. It will be more acceptable and better utilized.

   b. It will usually concern: an adjustment to change, facing death, affiliating with one's own age group.

   c. Cognitive therapy (Beck, 1976 re: distortions in thinking) can be very effective in relieving depression, sometimes seen as

dementia when actually it is depression.

d. Group work.

e. Existential framework research.

f. Jung, interpretation of dreams, especially more involving denial and death anxiety.

g. Strong desire to resolve problems in living.

D. Common themes in psychotherapy

1. Wish to undo some patterns of their life. For example, negative attitude or a worrying desire (Costa & McRae: neuroticism is likely to be stable over life but there is a possibility for change.)

2. May not want to ritualize patterns. Everyone has a right to denial. It can be helpful. There is a psychological need for acceptance of self and events of one's life. That is, one needs a sense of living one's own unique life. Persons need to reach conclusions about the legacies they are leaving for future generations. They need to be comfortable with their self-esteem intact.

3. What tends to remain stable without one of these types of "change agents" is:

   a. One's sense of well being,

   b. One's degree of sociability,

   c. One's activity level as competence and achievement have developed.

4. What tends to change: According to Gutmann (1978) the sex role shows a reversal. As women age they tend to develop more aggressive instincts or assertiveness ability, a greater competence and achievement level. A woman may move into a career as she sees herself as more than a mother and wife. She asks: Who am I as a person apart from my roles? The male may become much more tolerant of his gentleness and nurturance abilities as he ages. Men are often more involved in child care in middle and old age. Gutmann's research suggests there is role reversal; however, other interpretations indicate a less dramatic shift.

5. An issue: Do older people truly become more interior, more passive in their coping in old age? (Neugarten, 1973). Or, is there simply a reduction in activity level and an increase in reflection on life? Most of our research is biased by cohort differences which leaves us with unanswered questions. As a new generation reaches old age, the conclusions from research may show new patterns of living in the last years of life.

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CHAPTER 8. RELIGIOUS PLURALISM AND THE AGING NETWORK

The objective of this unit is to understand the similarities and differences in the organizational structure of congregations and aging agencies and the implications for collaboration. Successful collaboration depends on an understanding of the unique roles, characteristics and the organizational language of each. In some ways this is easier to do with aging agencies that are a part of the aging network than with pluralistic religious groups.

Congregations are those gatherings of persons whose members have assembled themselves together in voluntary pursuit of religious purposes, such as worship and service to themselves and others, and are bound by a common rule. The organizational structure is designed to carry out the rituals and purposes of that religious faith. As such, the congregation's primary source of support is contributions of members who carry fiscal responsibility for buildings, properties and programs of the congregation. Funding and decision making depends on boards composed of volunteers who have been designated congregational leaders.

The aging network, as used here, was created by the Older Americans Act of 1965 (OAA) and refers to state units on aging established by the Act and all of the service providing agencies which receive federal funds by contract under the OAA. Some of these agencies are non-profit organizations that receive only a portion of their budget from government funds. Although some agencies have Boards of Directors and volunteers who raise funds, when they provide services as part of the aging network with government funds, they are obligated to carry out the intentions of the Older Americans Act. A distinguishing characteristic of all aging network agencies, apart from this total or partial source of funding, is that their primary purpose is to serve older persons.

By the very nature of these two types of organizations, there are major differences between them even where there are similarities. Clergy represent a form of voluntary organization that depends upon a few paid staff and a large number of volunteers to carry out the programs and services. There is immediate ownership of that organization by those volunteers and a special status conveyed to them. Aging network agencies also have fewer paid staff than needed and must depend upon volunteers from various sources to carry out programs and services. Although these volunteers are essential to those agencies, they do not carry the organizational status or clout of congregational volunteers.

Another difference centers around the designated work week of clergy and agency staff. For clergy, weekends are the heavy work periods. For agency staff, weekends are usually their non-work time. Unlike agency staff who may have occasional evening meetings, clergy spend a large portion of their work time in evening meetings when congregation members are free to attend.

The Older Americans Act, first enacted in 1965, established state units on aging and authorized funds for each unit to initiate local community projects and to provide social services to older persons. Milestones in this act and its amendments are indicated. These contain the basis for the development of the aging network in the United States. Organizational charts of the aging network are presented. These will aid the clergy participants in understanding the purposes and functions of the aging network.

There is no such clear organizational chart for the pluralistic congregations. Each has its own unique form. However, most have some hierarchical format and a formal statement of congregation rules and regulations. Unfortunately information about these is not available in any one publication. It is necessary to contact the administrative headquarters of the group and request information. Most of these are listed in the Yearbook of the Churches or similar denominational or faith group publications.

In preparation for this session assign Chapters 3, 9, and 10 in Tobin, Ellor and Anderson-Ray. Additional sources about the three major faith groups, are in chapters on Catholics (9), Jews (10) and, Protestants (11) in Erdman Palmore, (Ed.). (1984). Handbook on the aged in the United States. Westport, CT.: Greenwood press.

The following papers provide approaches to achieve the purposes of this unit: A Panel of Clergy by Brewer and Jackson, and The Aging Network by Cheryll Schramm.

A PANEL OF CLERGY

Earl D. C. Brewer, PhD & Mance C. Jackson, DMin

It is important to understand differences in congregations growing out of their traditions and denominational structures. One way to do this is to have a panel of clergy make a presentation to the continuing education course. Such a panel should represent the various faith traditions present in the community. The range of such traditions may move from a loose-knit charismatic group to a formal episcopal form of church government. Where possible the panel should include clergy from Protestant and Catholic churches and Jewish synagogues. It should also include clergy from Black congregations. In some cases, representatives from ecumenical organizations could be included as well.

Each panel member should feel free to tell the story of his or her own congregation, its uniqueness, structural and power arrangements and how to approach it. Such stories would range from the local congregational control of Baptist and similar traditions to the hierarchical control of episcopal groups such as Methodists, Protestant Episcopal and Catholic. The Jewish synagogues with their emphasis on families provide another model. This pluralism of religious groups needs to be recognized and respected.

Where the congregation is fairly independent and makes decisions on its own through the clergy or a committee of lay persons, a direct approach is appropriate. Where there is hierarchical control over congregations, it may be important to contact the overhead organization before going to the congregational leadership. Approval of the hierarchy may improve the cooperation of the clergy and congregation involved.

In approaching a congregation, it is advisable to contact the clergy person first. Frequently, the clergy will want to visit with persons from outside the congregation interested in the welfare of older adults. He or she may refer the seeker to a member of the staff or to a member providing leadership in this area.

All congregations are within some religious traditions and sets of beliefs and practices. It is important to be aware of these and to honor them in efforts to stimulate cooperation and assistance in meeting the needs of the elderly. This may become especially important in congregations which are very different from the beliefs of the community staff person.

The Black Churches have unique characteristics which should be known by persons seeking their cooperation in community

programs for the elderly. The pastor is the head of a local congregation. The Black Church is an all-inclusive term for churches owned and controlled by Black Americans. All types of denominational policy are represented. Nevertheless, in a Black Church, the pastor is expected to have the gifts, talents, abilities and skills to lead, guide and direct the congregation in all areas of its life.

The pastor is always the safest point of entry. He/she is not the only point of entry and in many situations, may not be the easiest and most effective point of entry. Yet in terms of community protocol, the pastor is the point of entry. The "shepherd" wants to know what and who is at work in the flock. An outsider who would enter the flock except through the "shepherd" is suspect. A worker in aging who wants a congregation's cooperation will put forth diligent effort to reach the pastor before having serious discussions with any member of the congregation.

The point is that one's approach to entry into a Black congregation will depend on how one understands the Black Church. One may put forth some effort to understand it and, thereby, find effective ways to enter its system and accomplish desired goals, or one may blunder his/her way into it and hope for the best. An experienced or thoughtful worker with the elderly wants results and approaches any system only after some analysis of it. Those who would get results as liaison persons, enablers, recruiters or trainers with either clergy or laity of Black Churches must spend some time in careful preparation before taking the first step in their direction.

A lively panel of clergy could explore in depth these pluralistic issues and provide a basis for understanding congregations to agency persons working with the elderly and, perhaps, to clergy in search of new ways to be in faithful ministries to, with and by the older persons in congregations and communities.

RESOURCES:

Mance C. Jackson, D.Min. (1989). Importing the black church for ministries with the elderly. In Barbara Payne and Earl D.C. Brewer (Eds.). Gerontology in Theological Education. New York: Haworth Press.

THE AGING NETWORK

Cheryll Schramm, MSW

The purpose of this unit is to assist church staff and lay leaders in identifying appropriate services for their older members. It is important to provide information on the Aging Services Network, both locally and nationally. Invite a staff person from the State Office on Aging or your Area Aging on Agency Director to make this presentation.

I. Suggested outline for the initial presentation on the Aging Network.

A. An overview of the national system including information on the Administration on Aging, the State Units on Aging, the Area Agencies on Aging and the local service providers.

B. Information on the Older American's Act which created the network and continues to provide monies to fund priority services.

Resources: To facilitate an understanding of the system and the Older Americans Act, attached are Figures 8, 9, and 10. A series of slides were developed for this purpose and can serve as a model. They may be secured from:

The Atlanta Regional Commission
Aging Services Division
3715 Northside Parkway
200 Northcreek, Suite 300
Atlanta, GA 30327

C. Local aging services network detailing which agencies provide which services, such as, information and referral, senior center services, congregate meals, home delivered meals, homemaker services, home repair/chore, adult day care, respite care, case management, transportation, senior employment, legal and ombudsman services and services for Alzheimer patients (Appendix B).

Resources: Include any directories or lists (e.g. of retirement communities, hospitals, nursing homes, personal care homes).

Throughout the presentation, the importance of entering the continuum of care service system at the most appropriate level should be emphasized.

Figure 8. OLDER AMERICANS ACT

DATE	MILESTONE	IMPACT
1965	Older Americans Act	First enacted. Title III: Authorized state units on aging and authorized funds for each unit to initiate local community projects to provide social services to older persons.
1972	OAA Amended	Title VII: Provided funding for local community projects to provide nutrition services (1 hot meal/day, 5 or more days/week) to persons 60 and over.
1973	OAA Amended	Required state units (1) to divide state into planning and service areas (PSA's); (2) to determine in which areas an area plan would be developed; and (3) to designate an AAA to develop and administer a plan in each area. Title V: Provided funding for developing multi-purpose senior centers.
1975	OAA Amended	Specified that "priority services be provided under State plans: access, in-home services, and legal services."

DATE	MILESTONE	IMPACT
1978	OAA Amended	Consolidated under Title III, social services, nutrition services, multipurpose senior centers, formerly Titles III, VII, and V respectively, to eliminate duplication and emphasize a single "focal point" concept for service delivery.
1981	OAA Amended	Reinforced basic direction of 1978 amendments and expanded the capacity of state units on aging and AAA's through increased administrative flexibility.
1984	OAA Amended	Clarified and reaffirmed the roles of state and area agencies on aging in coordinating community-based services and in maintaining accountability for funding of priority services. Gave state and area agencies more flexibility, and added a new Title VII - Older Americans Personal Health Education and Training Program.
1987	OAA Amended	Established on Office for American Indian, Alaskan Native and Hawaiian Native Programs within AOA. Under Title III, established a new Part D to provide in-home services for the frail elderly; a new Part E to assist States in meeting

DATE	MILESTONE	IMPACT
		special needs of older persons (i.e. those in greatest economic and social need); a new Part F supporting preventive health services for the elderly; and a new Part G to assist States to provide programs to prevent abuse, neglect and exploitation of older individuals. Required each State to establish an Office of State Long-Term Care Ombudsman.

Source: Federal Register, Wednesday, March 2, 1983, "Grants for State and Community Programs on Aging. . . . .". "OAA: 1965-1985, 20th Anniversary", and Federal Register, August 31, 1988.

Figure 9.

THE ADMINISTRATIVE AGING NETWORK

The federal organization that makes the Older Americans Act a reality is the Administration on Aging (AoA). AoA currently is placed in the Office of Human Development Services within the Department of Health and Human Services (OHDS/DHHS). The administrative network reaches through the 10 regional offices of DHHS to the 57 State Units on Aging (SUAs) and some 664 Area Agencies on Aging (AAAs).

Presidency

↓

Department of Health and Human Services

↓

Office of Human Development Services

↓

Administration on Aging

Recommends policy, develops regulations to implement the Older Americans Act, allocates and administers OAA budget, grants for research, training, model projects, etc.

↓

Regional Offices on Aging (10 Regions)

Provide technical assistance to states and monitor state aging programs

↓

State Units on Aging (57 Jurisdictions)

Coordinate state-level activities on behalf of older people, develop and administer the state plans on aging, serve as advocates, provide technical assistance to Area Agencies on Aging

↓

Area Agencies on Aging (664)

Develop and implement the area plans on aging, serve as advocates for older people, coordinate with other agencies and organizations in the planning and service areas to develop comprehensive aging service systems, administer Older Americans Act programs within their jurisdictions

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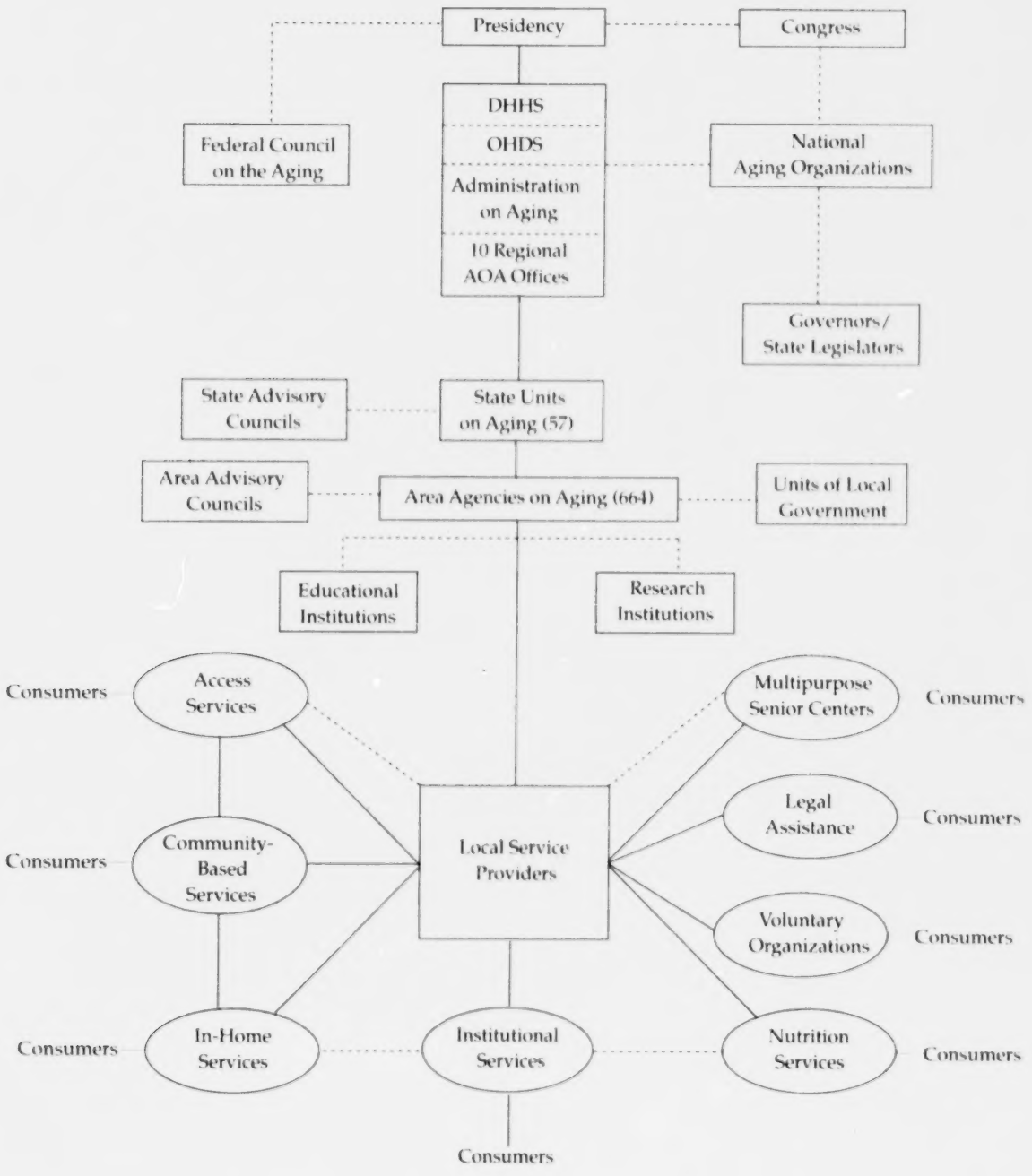
Figure 10.

THE NATIONAL AGING SERVICE NETWORK



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II. Suggested second presentation on the Aging Network concentrating on long term care issues with particular emphasis on the Community Care System and the Aging Network.

The Community Care program provides community based services to the frail, at-risk elderly population, helping them avoid unnecessary institutionalization.

Resources: If possible provide a handout detailing the Community Care program in your area. Case examples for discussion would assist students in understanding how the system works. Because the community care program is a Medicaid waiver project, it may be necessary to provide information on Supplemental Security Income (SSI), the overall Medicaid program, Social Security and Medicare.

III. Suggested for the third and final presentation on the Aging Network system.

Distribute three case studies (for example, Figures 11, 12, 13) prior to the class along with an aging service directory for your area. Allow time for reviewing the directory particularly in reference to the importance of accessing services at the most appropriate level. Give the class a local resource directory and intake forms they can use in their congregation and ask each to review the three case examples, complete intake forms on each case, and then use the directory to identify resolutions.

Resources. Discuss in class the importance of collecting information from clients and helping the clients and their families use the Aging Services Network. Class participants should be encouraged to establish a resource center in their particular congregation or agency and to make maximum use of any directories.

IMPLICATIONS

After the presentations on congregational organizations and the aging network organization, schedule time for discussing the implications for collaboration. The leader might begin with the following observations.

An appreciation of the human and physical resources of congregations and aging agencies will open up new avenues of collaboration. It can be expected that the aging agency staff will have more experience and the organization to deliver support services to older people in the local community. However, the congregations reach older persons unknown to the agencies.

Figure 11.

Case Number One:

John and Mary Black were both in their late fifties and active members of the Marietta Methodist church. John had just been told that he would have to take early retirement from Lockheed where he had been employed the last 23 years. His last day of work would be June 30. John's work had been his only interest for a number of years and he was devastated.

Mary, his wife of 25 years, had never worked outside of the home. They had decided that she shouldn't work while their children were still in school. Their youngest child was now a senior in high school, the middle two were still in college, and the oldest was in the Army stationed in Germany.

John had always earned enough to live comfortably and to send his children to colleges of their choice. Their home was almost paid for but taxes, insurance and utilities had steadily increased and with ongoing expenses the Blacks had little opportunity to accumulate much savings. Upon learning about Lockheed's layoff, John became very depressed and couldn't see any way he would be able to handle all the college expenses let alone the day to day expenses. He knew he would have to get another job but since he was so specialized he realized that it would be a difficult task. And the more depressed he became, the more Mary became depressed. Mary had been going through a difficult time in life any way with her last child getting ready to leave home and she was not finding any activity that had particular meaning. She felt she could give little support to John and felt totally inadequate.

Neither Mary nor John wanted to worry their children but did share some of their fears with one of their closest friends who, in turn, talked to Reverend Solvall, the minister at the Marietta Methodist church. Fortunately, Reverend Solvall was just completing a gerontology course and was able to quickly spring into action.

Action Plan for Case Number One:

Figure 12.

Case Number Two:

Cathy York and her husband Jim were both in their early forties and had just bought a new five bedroom home in Dunwoody because Jim's mother had recently moved to Jim and Cathy's city of residence. Jim's father had died and Jim insisted that his mother, age 73, move in with them. Both Cathy and Jim were employed full time and did not feel "Grandma York", the name adopted by the York's entire family, would be any trouble.

The York's family were members of St. Peter's Catholic Church but for the last several years Cathy and Jim had not attended regularly. They had joined a Sunday morning mixed doubles tennis team at the club. However, they would generally drop off their three children, ages 15, 11, and 9 to Sunday School and Grandma York to Mass.

Grandma York had made few friends since moving to the city. She did not drive and spent most of the time at home. The children were all busy with their own activities and Cathy and Jim were rarely home. Their full time maid was pleasant but had little time to visit.

As the months passed, Grandma York's health, both physical and mental, started to deteriorate. She started staying in bed longer and longer in the morning and felt tired all the time. She also started to appear more and more confused. Jim thought that his mother was just adjusting to his father's death but decided that he should take over her financial affairs so she at least wouldn't have that worry. Grandma York didn't put up much fuss but withdrew more and more.

One Sunday morning she decided not to go to Mass and thought she would surprise the family by making Sunday dinner, something she had enjoyed when her own family was at home. Unfortunately, the operation of the burners on the stove was confusing and Grandma York burned the potatoes and vegetables. When Cathy, Jim, and the children returned home, smoke was everywhere. The smoke alarm was blaring and Grandma York was crying. Cathy York was furious since she had just had the kitchen repainted and she started screaming. Jim, in turn, was angry that Cathy was over reacting and stormed out of the house. The three children were upset since everyone seemed to be angry or upset.

Family tension grew over the next several months and Grandma York rarely ventured out of her room. Cathy and Jim argued constantly and the children started having problems

at school and Sunday School. Jim finally realized something had to be done and called the Whispering Wind Nursing Home, a facility close to his office and said he needed to arrange for his mother to be admitted. When he found out the cost would be over $2,000 a month, he became desperate. His mother's income was $500.00 a month and he could barely make ends meet for a family of five let alone an additional $1,500 a month. The nursing home's social worker arranged an appointment for Jim with Vera Brite, a Community Care Case Manager. Vera tackled the case with vigor.

Action Plan for Case Number Two:

Figure 13.

Case Number Three:

Dorothy Price and Eleanor Elwood were sisters and both were widows. Dorothy was 61 and a Licensed Practical Nurse, Eleanor was 77 and had been a homemaker all her life. Both Dorothy and Eleanor received approximately $600 per month which was barely enough to pay rent and other day to day expenses. (Eleanor received social security and railroad retirement and Dorothy was employed part time). Since they had lived in the same town and had always gotten along, they decided to live together and share expenses. The arrangement had worked reasonably well over the last two years and Dorothy was thinking about taking an early retirement and drawing her social security at 62.

Both Dorothy and Eleanor had been fairly active in Temple Sinai when they were younger but they didn't feel they had much in common with the members anymore. Many of their friends had moved or died and it just wasn't the same. And since Dorothy still worked she had not gotten too involved in any other activities. Eleanor, in turn, enjoyed keeping house. She felt Dorothy needed her at home so she limited her activities outside the home.

One Sunday morning Dorothy walked out of their apartment to get the newspaper and fell down a flight of stairs. Luckily Eleanor was home and called the ambulance immediately. Dorothy had broken her hip and stayed in the hospital for several weeks. Eleanor, after assuring the doctor she could care for Dorothy, assumed responsibility for Dorothy's recuperation at home.

Dorothy, who had always been very independent and a nurse for over 40 years, knew exactly what had to be done and began giving Eleanor daily instruction. Unfortunately, Eleanor was not as experienced as Dorothy in caring for the sick and couldn't measure up to Dorothy's expectations. Dorothy became more and more frustrated and became angry that Eleanor couldn't adequately assist her in and out of bed and with similar needs. Dorothy was also worried about all her medical expenses and her loss of income.

Eleanor who had hurt her back when trying to help Dorothy turn over, kept trying to keep Dorothy comfortable while at the same time cook all the meals and keep the house clean. Eleanor was exhausted and started to resent Dorothy's demands, but she felt a deep responsibility and said nothing. She started eating less and less and couldn't sleep. After several weeks, she herself became confined to bed with a high temperature.

Fortunately, as luck would have it, their next door neighbor, Seymour Pluses, a social worker with the Department of Rehabilitation and member of Temple Sinai, was just completing a seminar through the gerontology program at the State University and knew exactly where to begin.

Action Plan for Case Number three:

The congregations have physical structures in the midst of the local communities where the older people live. Older people are familiar with their structure and may view them as more accessible and friendly. They may be free of the negative attitude of many older persons toward government programs or programs that appear to be government sponsored even if they are not. With these comments give the participants an opportunity to suggest implications for their agency and/or congregation.

CHAPTER 9. CONGREGATIONAL AND COMMUNITY PROGRAMMING

Betsy Styles, MS

The purpose of this section is to familiarize the participants with cooperative congregational programming and to introduce some successful models and resources for planning and implementation.

In preparation for this session it is important that the participants study carefully Chapters 2,3,6,7,9 & 10 in Tobin, Ellor and Anderson-Ray. This is one of the few resources on cooperative planning, and the only one we could identify that addresses program collaboration between religious institutions and community service agencies.

The suggested outline for this session is:

I. Congregational programs for older adults

   A. Types of programs and activities

   B. Options for planning

   C. Who does the planning

II. Collaborative programs

   A. Congregations and service agencies

   B. The community advocacy model

      1. Tobin, Ellor and Anderson-Ray
      2. Types of cooperative programs and services

III. The ecumenical model

   A. The Shepherd's Center model

   B. Reaching Out To Senior Adults (ROSA)

CONGREGATIONAL PROGRAMS FOR OLDER ADULTS

The type and level of activity sponsored by congregations and synagogues vary. They are based on the congregation's doctrine and interpretation of their purpose, and on an understanding of and sensitivity to older persons. Some of the programs and services are informal, some formal. Both are important.

The clergy survey, conducted for this project, (see Chapter

4) provides information about types of activities some congregations are offering. Prayer and worship was the most frequent activity and AARP meeting place the least. However, over half of the clergy said that their congregation hosted the activities of other organizations. The most frequent programs were home visits, congregate meals, study groups and counseling. Less than one third listed meals on wheels and arts and crafts. Over half of the congregations had programs honoring the older members. Two thirds of the buildings were barrier free and over half of the congregations were involved with community agency programs.

This information may be used to compare the programs and services listed by your participants on the first day of the training program.

Tobin, Ellor and Anderson-Ray found that the services provided by congregations fell into four basic groups: (1) providing religious programs; (2) serving as a host; (3) providing pastoral care programs; and (4) providing social services (See Chapters 2 & 3 for a discussion of these groups.) Also, they suggest three ways a congregation can develop programs and services: (1) develop programs independently and rely on their own expertise and resources; (2) initiate or join an ecumenical effort; or (3) choose to cooperate with a service agency. Some combination of these three may also be offered.

COLLABORATIVE PROGRAMS

This section is based on the three year project of Tobin et al., called the Community Advocacy Model. The goal was to increase interaction between congregations and service agencies on behalf of older people. Chapter 9, of Tobin et al., reports on the project. The first phase of the project was devoted to becoming familiar with the community agencies in six selected communities in the Chicago area. The second phase was a systematic survey of clergy and agency staff in each community. The purpose was to provide a profile of the needs of the elderly as perceived by the clergy, and to inventory church and synagogue programs and the willingness of clergy and agency staff to collaborate and participate in developing services.

The third phase was to share the results of the survey at a meeting of clergy and social service agency representatives. The findings were discussed, and plans for future activities considered. At this meeting the community leaders took responsibility for planning and initiating programs.

Participants in the training might build their projects around this model. A study of the experiences with the Community Advocacy Model provide guidance in the planning and operation of

such a project, some pitfalls to avoid, some problems to expect, and some keys to success.

This model takes time to build solid relationships and trust and requ res a long period of consistent hard work. Those who elect to implement such a model need a long term commitment.

ECUMENICAL MODELS

Shepherd's Centers. A Shepherd's Center is a community organization formed through the cooperation of local churches and synagogues. It is an ecumenical outreach to the congregations within a specified service area of about fifteen square miles. The pilot and model was organized in Kansas City, Missouri in 1972 by Dr. Elbert Cole and a group of clergy and older persons. The success of the original program has led to the organization of more the 70 centers in the United States and in several other countries. This growth has led to the organization of Shepherd's Center of America to assist in the development of Shepherd's Centers, to provide training for leaders, and a form for the Centers.

The goal of the Shepherd's Centers is to sustain older people in their homes and engage them in meaningful activities which give purpose to life. The older people participate in the planning and operation of the center. More specifically, the objectives are: (1) to sustain the desire for independence characteristic of most elderly people; (2) to offer an integrative approach in meeting individual needs by bringing a wide variety of services from one center; (3) to focus on the elderly of a specific geographical area, small enough to accomplish the goals of the center; (4) to provide opportunities for the elderly to serve and engage in meaningful activities; (5) to avoid isolating the elderly from the rest of the community; (6) to develop a model which could be duplicated elsewhere in the city and in other communities; (7) to make more effective use of existing community resources and programs designed to help those 65 and over.

Handouts are provided for each student on philosophy and uniqueness from the Shepherd's Center manual. A VCR is available from the Gerontology Center of Georgia State University that visually presents seven such centers. It is divided into: 1 location; 2 uniqueness; 3 how to start a Shepherd's Center; 4 theology. This tape allows the student to visually perceive the model and gives them a resource for further use in their community. The clergy appreciate the theology section.

SHEPHERD'S CENTER GOALS AND OBJECTIVES
& PRIMARY CHARACTERISTICS OF A SHEPHERD'S CENTER

1. Responsibility is vested in older adults themselves.
It is critical to the success of Shepherd's Centers that older adults assume the responsibility for their lives, for the development of programs affecting them, and for the entire community. The opportunity for meaningful involvement attracts a diversified group of older people, from blue collar to professional. Traditional roles normally assumed by paid career staff are assumed by volunteers. The few paid staff that may be required are often older adults as well.

2. The focus is on the community.
The Shepherd's Center is a model which strengthens the community through cooperative relationships and effort. The focus on a neighborhood utilizes the knowledge that older people possess concerning their community. Volunteers are better able to function where there are shared values, geographical similarity, and common needs. This focus enables both participants and volunteers to strengthen social bonds.

3. Churches and synagogues are viewed as essential components.
A criterion of Shepherd's Centers is that they have the support and sponsorship of churches and synagogues in their area. Churches and synagogues provide program and office space, financial support, volunteers, and publicity through bulletins and newsletters. In the faith community, people naturally ask what they should be doing for their neighbor. A Shepherd's Center goes beyond meeting physiological needs to address quality-of-life issues and needs; thus it is an expression of the faith community, but does not promote the religious values of any one denomination. In fact, there is usually a high percentage of participants and volunteers who have no congregational affiliation.

4. Unmet needs are a priority.
Because Centers are based on a cooperative community model, a partnership exists with other agencies and institutions. Shepherd's Centers do not duplicate existing programs and services. In fact, a Shepherd's Center promotes the programs and services of other agencies in its effort to ensure that community needs are met. If a Shepherd's Center is in competition with another program, it is likely in conflict with its own philosophy.

5. Financial support comes from the private sector.
Because the Shepherd's Center is a volunteer model and utilizes existing space for its program, the cost of operating is kept very low. Centers derive financial

support from diverse community sources, including individual donations, fees, church and synagogue contributions, local businesses, corporations, foundations, and civic organizations. As a result, the community develops a keen sense of ownership and knowledge of the Shepherd's Center. The knowledge that older adults possess of community resources enables them to raise funds very effectively. Furthermore, in most Centers individuals 55 and over contribute from their own funds anywhere from 30% to 60% of their budget requirements.

There are seven Shepherd's Centers in metropolitan Atlanta. The Gerontology Center at Georgia State University has developed a VCR tape about these centers. It includes sections on location, uniqueness of the Shepherd's Center, how to start a Shepherd's Center, and theological basis. This tape may be borrowed from the Gerontology Center for a $10.00 handling fee.

Contact: The Gerontology Center
Georgia State University
Box 1032, University Plaza
Atlanta, GA 30303-3083

REACHING OUT TO SENIOR ADULTS (ROSA)

ROSA is a new ecumenical program organized by four students in the 1989 Atlanta Clergy and Aging Agency Training. The purpose of this program is:

1. To create awareness and sensitivity to the challenges which are faced by senior adults;

2. To provide an opportunity for senior adults to gain insight and information about financial benefits, wellness programs, intergenerational activities, social services and community activities;

3. To stimulate pastors and congregations to establish a senior adults ministry for the church and the community.

The planning committee and organizational structure for the initiation of the program has involved clergy and selected representatives from the first seven churches planning the program and an advisory committee.

Their first meeting was to introduce the program at a "Focus Meeting." They have conducted a survey of needs from older persons in the seven participating churches. A major project was an Outreach Day open to all congregations and older persons. The one day program included information booths, seminars on social security staffed by a district manager, on SSI, health, crime, an

onsight Social Security office open to the public, and free health care screenings. Over 500 persons participated from 27 churches and agencies.

For additional information about this program contact Ms. Normal Phillips, Director, Programs Policy Branch, Social Security Administration, 101 Marietta Tower, Suite 1902, Atlanta, GA 30301, (404) 331-2998.

RESOURCES:

Clingan, D.F. (1983). Aging persons in the community of faith (rev. ed.). St. Louis, MO: Christian Board of Publication.

Older adults ministry a resource for program development. (1978). Atlanta, GA: Presbyterian Publishing House.

Styles, B. (1989). Congregational programming for older adults. in B. Payne & E.D.C. Brewer,(Eds.). Gerontology in theological education: Local program development. New York: Haworth Press.

Tobin, S.S., Ellor, J.W. & Anderson-Ray, S.M. (1986). Enabling the elderly. Albany: State University of New York Press.

CHAPTER 10. COMMUNITY RESOURCES

Barbara Thompson, MDiv, MS

The Community Resources section of the curriculum can provide participants with a working knowledge of services and programs available from governmental agencies and local community organizations. This builds a base from which referrals can be made by clergy in counseling with congregation members. It may provide new awareness of additional resources for agency staff, and it gives them an opportunity to share the services of their agency with the other participants. Additionally, this knowledge base is an important dimension for the networking that will be necessary to plan and execute collaborative projects.

There are at least three areas of resources to take into account in planning this section of the curriculum: (1) governmental agencies: federal, state, county; (2) community agencies from the non-profit and private sectors; (3) state or local affiliates of national organizations that make resource materials available around aging issues.

This curriculum section could be presented in one day or on several days when appropriate to other curriculum areas. Identification of resources needed or other available community resources noted by course participants could provide additional data for this section. It is suggested that adequate time for discussion be provided. Participants will respond actively to persons who work daily with these community services and programs.

Learning goals for this section of the curriculum could include:

1. Gain some knowledge of the vast array of governmental, national organization and local community resources available to older persons;

2. To gain sufficient information about organizations and resource persons to begin networking for planning and development of collaborative projects.

SUGGESTED GOVERNMENTAL RESOURCES

Many course participants will not have comprehensive knowledge or up-to-date information on regulations concerning such major programs as Social Security, Medicare, Supplemental Security Income and Medicaid. This information can be essential when working with older persons and their families.

1. Social Security Administration.

Social Security is a package of insurance benefits provided by the federal government for all persons who meet the eligibility requirements. It is a base from which to build rather than a comprehensive retirement or disability income program. Information in this area should include:

a. A general explanation of how the Social Security system works;

b. The various benefit programs under Social Security including eligibility and computation of payments for each;

c. Retirement benefits;

d. Survivor benefits;

e. Disability benefits;

f. Supplemental Security Income and medicaid;

g. Medicare.

Resources:

One or two employees of the Social Security Administration from a regional, district or local office knowledgeable about each of these areas would be the best resource. They would have official and current published materials to share. Medicare is administered by the Health Care Financing Administration and someone from a regional office might be accessible to the training site. The American Association of Retired Persons has published a pamphlet on Catastrophic Coverage Under Medicare and may have knowledgeable volunteers who can assist with discussion of medicare issues.

2. Legal Services.

The Older Americans Act has mandated that legal assistance be made available to senior citizens everywhere. Therefore, across the country there are legal services contracted through Area Agencies on Aging. In rural areas a legal services office may not be in every community, but they can be found within 50-60 miles. These services may go under the name of Senior Citizens Legal Services or some other similar name. The program may be contracted through Legal Aid Services or a state legal services program. There are no income restrictions, but the program does target lower

income persons. Persons must be 60 years and over. Legal services tend to concentrate on such cases as:

a. Public benefits, including income and appeal issues concerning pensions, Social Security, Supplemental Security Income;

b. Health care issues including eligibility requirements for Medicare and Medicaid, transfer of assets, review of Medicare payments, as well as issues concerning medigap insurance plans;

c. Issues of legal guardianship and powers of attorney;

d. Consumer fraud issues including those around loans, foreclosures, contracts, quality of work performed;

e. Wills, estate issues, living wills;

f. Elder abuse and neglect issues and remedies.

Resources:

A good resource would be the Director of the Area Agency on Aging legal assistance program or person from the state legal services program or a Governor's Office of Consumer Affairs. Non-governmental sources would be, for example, Legal Aid or an attorney who handles such cases. In metropolitan areas and larger cities there may be a Bar Association program for volunteer legal services for older persons.

3. Area Agency on Aging Services Funded by The Older Americans Act.

(AAA) All AAAs have a range of services mandated by the Older Americans Act that are contracted through local service providers. These services provide a continuum of care to assist older persons in maintaining independent living.

Resources:

An Area Agency on Aging Director in the area who may be the Site Coordinator for the training or a participant in the group.

4. Department of Family and Children Services, Adult Protective Services.

Resources:

A staff person from the Adult Protective Services office of the county Department of Family and Children Services.

5. Special State or County Programs for Older Persons.

6. City or County Parks and Recreation Department.

Such departments often have special older person leisure, recreation and education programs.

COMMUNITY ORGANIZATIONS OR LOCALLY INITIATED PROGRAMS

The variety of resources can be as broad as the communities in which the training is located. Some of the categories of organizations to locate might be:

1. Hospitals with special assessment or evaluation programs for older persons (Psychological, physical, social), special services for insurance claims and counseling, and hospice programs;

2. Support groups for various health problems, widowhood;

3. Adult day care centers;

4. Transportation programs;

5. Leisure and recreation programs including drama and music groups;

6. Employment programs;

7. Elder abuse and neglect programs;

8. Retirement or senior living communities;

9. Home health services;

10. Services for the vision and hearing impaired older person;

11. Insurance and financial counseling services for older persons.

SELECTED NATIONAL ORGANIZATIONS WITH LOCAL AFFILIATES

1. American Association of Retired Persons.

The American Association of Retired Persons (AARP) is a national organization of some 30 million members with local chapters in most communities across the country. AARP provides a large number of educational and community service programs on aging issues and concerns.

Resources:

AARP publishes a large catalog of materials: AARP Publications and A/V Programs: The Complete Collection. For this catalog and lists of regional offices and other resources contact:

American Association of Retired Persons
1900 K. Street, N.W.
Washington, D.C. 20049

2. The Older Women's League.

The Older Women's League is a national organization founded to educate women of all ages about the special problems of women as they age. They also educate the general public about these special problems and actively work for change in public and social policy that will give economic equity to older persons. They work to change the general image of older women as fragile and weak to the real image of older women as useful and productive. There are over 22,000 members in some 150 chapters around the country.

For the names of knowledgeable Older Women's League speakers in your area or for published materials contact:

Older Women's League
730 11th Street, N.W. Suite 300
Washington, D.C. 20001

Some of the issues regarding older women to cover:

a. Women and caregiving. There are approximately 7 million caregivers nationwide and 3 out of 4 are women. Ninety percent of the disabled elderly are cared for at home. The physical, emotional and economic strains are greater in care for the elderly than in care for children. Working women are unable to care adequately for an ill spouse or parent. More long term services and policy are needed as well as respite care, caregiver support groups, adult day care centers and affordable in home care services.

b. Women and Employment. There is a myth that all older persons are affluent. The poverty level of older women, especially those living alone and minority persons, is very great. Older women often need employment to supplement their incomes in order to provide for basic needs. In order to enter the work force, older women need to learn new work skills and how to compete with younger workers. Age discrimination is rampant in the work place in spite of age discrimination laws. Most employed older women do not receive health insurance, vacations or other employee benefits and are given the lowest level of income for their positions. Self help groups, job clubs, and employment centers can provide services and supplement the two government funded programs for low income persons (Jobs Training Partnership Act and Title V).

c. Women and Housing. Many older women, most of whom live alone, spend 50% or more of their income for adequate housing. There is a major need for middle income women to have a choice of affordable housing.

d. Women and Health Care Costs. Most older women do not have health insurance that supplements medicare. The escalating costs of health care put them in jeopardy. Nutrition for older women living alone can be a problem due to poor dietary habits and insufficient income for a healthy diet.

Older Women Tend to be Invisible. Whether working or not, older women are often dismissed as an unimportant part of the social scene in the community. These older persons need to receive the respect and concern that preserves dignity.

3. Alzheimers Disease and Related Disorders Association (ADRDA)

This is a national association with local chapters in many local communities. These groups provide many services such as, support groups, home consultation, staff and volunteer speakers, and other program assistance. For more information about chapters contact:

Alzheimers Disease and Related Disorders Assoc. Inc.
70 East Lake Street
Chicago, Il 60601

4. The Visiting Nurses Association, Inc.

This is a national organization with affiliated local associations in most communities. For more information about resources and associations contact:

Visiting Nurses Association, Inc.
3801 East Florida, Suite 806
Denver, Co 80201

CHAPTER 11. COUNSELING ISSUES FOR OLDER PERSONS AND THEIR FAMILIES

Clergy and agency staff often find themselves in a counseling relationship with older persons. For clergy, this may be a significant entre for ministering to older persons. For agency staff it may be a necessary part of delivering services or it may be a significant dimension of the informal relationship with older persons in the process of service delivery. In either case, knowledge of counseling issues and development of counseling skills are needed. Especially important is knowing when to refer older persons to professional counselors. Another issue concerns how to work with the older person and family members around issues of agency: for whom is the counselor the agent, the older person or the family members making the request?

Generally learning goals for this curriculum segment focus on:

1. Identifying recurrent issues and problems in counseling older persons and their families;

2. Recognizing the differences in counseling older persons and their families in and out of institutional settings;

3. Awareness of the unique skills necessary for counseling older persons;

4. Awareness of the male-female differences in counseling older persons.

In the first presentation summary, Dr. Gary Arthur, Professor of Counseling and Psychological Services, Georgia State University-Ft. Benning, focuses on counseling issues in the non-institutional setting. He deals with selected counseling issues for older persons and their families and with skills needed by the clergy and agency staff who find themselves in a counseling relationship.

The second presentation is an essay with cases and questions for discussion that deals with relocation to an institutional setting. Pamela Ford and Mary K. Moore are persons who deal with older people and their families in this setting on a daily basis. The Wesley Woods campus in which they work includes four types of facilities: twin towers for independent living, an intermediate care facility including an Alzheimers section, a skilled nursing facility, and the Geriatric Diagnostic Hospital.

COUNSELING ISSUES AND SKILLS IN THE NON-INSTITUTIONAL SETTING

Gary L. Arthur, EdD

The needs of older persons are no different from persons of any age. What we tend to recognize is that he/she could use more or less than they presently possess, that is, better health, more money, less stress, or less distance to travel. Counselors may need to adjust their expectations when working with the older client. That is they might not engender hope as leverage for change but counsel for acceptance of what is likely to be. For many older persons this means validating and confirming patterns they have developed over the years.

When it comes to therapy, older members of families have remained at a distance from the clinics. Yet, they are one of the most underserved mental health treatment population. Many avoid seeing someone because they don't define their difficulties as mental health problems. Perhaps they still see a stigma associated with being a mental patient or have not located a sensitive and understanding counselor their age.

When counseling the older client it is wise to recognize the power of the past. Even though the majority of concerns are in the present, these problems are laced with the past. The older client often will present a problem as having to do with how they are being treated and with subtle shifts in their identity taking place.

It seems trite but human beings require a sense of control over their experiences. If we are able to attain a sense of control, impending threat is diminished. A set of rules dictate the quantity and quality of interactions and are a clear indication of human beings' recognition for the need for control in their lives. The forces shaping one's perception of control are in existence and are operating continuously. The process of socialization, an interpersonal process, is responsible for the building of one's relationship to one's sense of power. The need for control is the framework for "personal power". For the most part this power represents the capacity to influence. If one attempts to influence anything, one is attempting to exert control.

Many clients finding themselves in positions of being influenced by others feel they are in a dependent relationship. Others have received distorted feedback, made incorrect conclusions about experiences and accumulated losses all of which reflect a distorted perception regarding control. Control strikes at the very heart of autonomy and imposed standards. Personal effectiveness, a desired state, is the sense one has of the capacity to influence the condition of one's own life. To

remain independent the older adult must:

1. Retain financial self-sufficiency;
2. Live in their own independent household;
3. Move freely about the community;
4. Mentally be able to cope with day-to-day decisions;
5. Have opportunity to give as well as receive decisions;
6. Have at least fair health. (Atchley, 1987)

IMPLICATIONS FOR OLDER PERSONS IN AND OUT OF NURSING HOME SETTINGS

1. Personality styles appear to dictate various levels of social interaction. In general, a sustained companion or counseling relationship is more beneficial to older persons than shorter ones in which the older person sees different persons over a period of time. For many older persons, it requires too much time and energy to get involved with one counselor after another.

2. The importance of friends, not just acquaintances, but persons with whom one earnestly shares their feelings is essential to the well being of healthy individuals. A sense of belonging is based on shared values. Thus, friends provide for perspective taking which is essential in continued validation of one's self-concept. This self-concept is a combination of one's performance in social interactions and how others react.

   However, gender differences need to be understood. Men tend to have very few good friends, maybe one or two. When they retire this can present problems for their spouses and for themselves due to feelings of loss of control and eventual helplessness. Men tend to be more passive regarding their friends while women place more value on them. For some women, if married, there is a tendency to invest too heavily in their male partner thus undermining their effectiveness in developing female relationships. Women's tendency to live longer can be a problem in developing close friends in later life. Gender issues have been re-focused today through pre-marital counseling concerning dependent-independent relationships, a rigidity-flexibility framework, equalitarian roles, and respecting one another's space.

   However, older people today haven't benefited from such pre-marital counseling and attitude changes. As a result of

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today's varied life styles and changing conditions, couples experience a variety of problems in the area of relationships.

3. Helping the elderly person <u>acquire permission from themselves</u> to be different or to establish normalcy for themselves is a major task of the counselor. Changes occur constantly across all parts of a person's life: physical, psychological, social, interpersonal. Many older people feel they cannot change basic meanings or adjust to what is becoming normal and acceptable. In fact, they do not know specifically what is normal and acceptable. Counselors have a role in helping them gain permission from themselves to be the way they are now. This is similar to working with family members of a dying person in allowing them to release the person to death or freeing-up the dying person to give themselves permission to die.

4. The primary counseling skill needed incorporates sincere, honest listening. This involves listening for the commonalities and connections in order to bond with that older person. The focus should be on the person, not necessarily on the content of their conversation. As the counselor relates with honesty and engenders personal integrity over time, he/she provides the necessary stimulation that will develop into an effective relationship.

5. A rotating series of different counselors or group work with the older client is very effective for some personality types. The variety and quality of stimulation serves as an important purpose for living. Some people have a high need for stimulation and become bored easily if stimulation decreases. They choose variety rather than depth.

SUGGESTED SMALL GROUP EXPERIENCE AND DISCUSSION

Assemble small sharing groups of 3-5 within the room to discuss for a few minutes the questions:

1. What scares you about growing old?

2. What scares you about working with older people?

Direct one half of the groups to discuss question #1, and the other half to discuss question #2.

<u>Areas that could emerge in discussion:</u>

1. Fears about growing older

a. Struggling with gradual memory loss;

b. Not being able to care adequately for your loved one and the resulting guilt and breakdown in quality of care and quality of life;

c. Dealing with chronic pain;

d. Not having a choice in the matter of loneliness, in choice of associations and relationships;

e. Financial situation, dwindling resources and the cost of health care;

f. Physical limitations and disabilities;

g. Loss of opportunities;

h. Restricted resources other than money; negative attitudes about older people.

2. Fear about working with older people

a. Fears about the person dying;

b. Physical issues and being able to respond to them;

c. Giving someone something they don't want;

d. Issue of who you as a counselor serve as agent. Are you the agent of the older person or the son, daughter, or other family member who asked you to see the older person;

e. Not having skills necessary to make appropriate assessments.

After reporting and some discussion, have the whole group focus on one or two of the fears identified and attach a feeling to them. For example:

1. To loss of memory: frustration, inadequacy, hopelessness;

2. To dependency vs. independency: sadness, anger;

3. To negative attitudes toward aging: depression.

After identification of feelings, for example, frustration from loss of memory, ask: WHAT DOES IT MAKE YOU WANT TO DO? Do you want to withdraw, isolate yourself or disengage?

Issues for discussion:

1. How do we get people to alter their feelings of withdrawal so they don't look upon what is happening to them as devastation?

2. How do you as a counselor cope with feelings of being manipulated by the older person's anger or withdrawal?

3. How does the counselor deal with this loss of control, a major issue reflected in most of the fears?

THREE CASE STUDIES FOR DISCUSSION OF SELECTED ISSUES FOR OLDER PERSONS

Case One. Larry is 80 years old. His wife has had a stroke resulting in loss of memory and inability to move about with the same freedom as in the past. Larry is still an active globetrotter. However, he has lost his wife and all of the shared experiences of their lifetime. The loss is painful and he expresses a lot of guilt and wishes it could be him in this condition rather than her. She is becoming more dependent. When he leaves her alone, she becomes panic stricken and afraid. This condition has reduced his choices. It is difficult to see her beg him to stay at home. He feels he needs to take her out in public, but she is very difficult to manage because she becomes panic stricken if she loses sight of him. She feels lost, gets angry and loudly chastises him even if he was only behind or to the side of her.

Therefore, what happens to a relationship when memory is affected? One has to lose memory in bits and pieces to realize that memory makes our lives. In our memories we find our coherence, our actions, behaviors, feelings. Without memory, in many ways, we are nothing.

What issues do you see surfacing for Larry (not the wife) as the client?

Some issues that could emerge in discussion

1. Expressing guilt, frustration, anger. What guilt and anger should one feel? Larry wants to live his own life and he is angry. There is a danger in confronting him about this anger at his wife's condition and setting in motion the vicious cycle of guilt, defense, guilt. We want to intervene in a way that gets below the surface.

   Guilt has different meanings and there are two levels of guilt operating here. Larry feels one level of guilt, but his reactions are to a different set of parameters

he has not even identified. This is why he is seeking help.

2. We can hypothesize dependency. Larry's wife is more dependent on him than ever before, and this is a new experience for him. Dependency breeds contempt and hate, and this is what he is feeling. It is expressed in his anger that he is restricted, unable to go places, for example.

3. The issue of control is important for each of us whether we are over or under controlled. Patterns of control affect us deeply and set up feelings of contempt. Larry does not understand what is happening to him or why this condition has happened to his wife. Those in a clergy setting may have a way to help because they represent that which binds anxiety, that is, religion and faith. Without a belief in a Master Plan or God to whom we can turn over our anger and frustrations in faith, many people would have great difficulty in dealing with this situation.

4. Reduced choices: Work with a spectrum of rigidity-flexibility and attempt to assist Larry in reframing his rigidity. He has almost as many choices as he had before. The problem is that the price is higher. It costs him more not just in money but in terms of himself. It is more difficult to travel or even go shopping when she accompanies him. They may need to take another person or couple with them. But, he still has the choice. He can continue to play golf, but he may need to provide support for his wife during those times. Ask him the question: What does this make you want to do?

In working this case and the following two, look at your own issues with aging in terms of feelings and what these feelings make you want to do. The reality in so many cases is in our sensory perception. It is in the visibility of what we can see, hear, feel, and taste. The person wants to see something so he/she can do something about it. For the overly controlled and rigid person, it is difficult to get them to back off their rigidity--flexibility framework that has served them well for so many years. This is especially difficult when it involves relationships with a significant other.

Case Two. Ruth is an 87 year old widow who has lived alone since her husband died 25 years ago. She had a long-term ailment that was progressive and necessitated use of an oxygen tank at times, but she was mostly able to take care of herself. She was ambulatory but used a walker. Her daughter who lived 100 miles away was not happy about the situation due to the condition of

her lungs. There were no other relatives living in the area. The daughter decided to move the mother to her city of residence for fear of what might be an impending tragedy. The daughter sold her mother's house, most of her possessions, and moved her into a semi-skilled facility.

The daughter was going through a traumatic divorce and was in counseling. She did not feel that she could or wanted to accommodate the mother's request to move in with her. In counseling she expressed great concern over the possibility of her mother's demise and her present condition which included constant telephone calls during the day. The daughter saw these calls as harassment. The therapist and the daughter thought the mother needed counseling as she had become depressed.

During the counselor's initial visit, Ruth attacked his diction several times. She cited how English was being brutalized and that he was no exception in this. He did not understand her outbursts but complimented her on picking up on the error. He recognized from the beginning that she did not want him there.

Then she said: "The thing I have feared most has come upon me." He wondered if she was talking about him but thought it sounded like a Bible verse. He asked her what she meant and she replied very seriously: "Figure it out."

The visit was tense and she did everything she could to discourage the counselor. She told him that she was a mean person and did not have many friends. Before he left she said: "Now see how the mighty hath fallen." He could only imagine that this proud lady was seeing herself in this state. He did not know anything about what she was feeling.

Earlier they discussed whether she needed counseling. She asked whether he thought she did. He answered that he did not know and would not until he had been with her awhile. She knew that she did not need counseling. He said, "All right but what should we do about it?" She said: "Do what you want, there isn't anything I can do about it." He made it clear that if she did not want him, he would not come back. She said, "Yes, but my daughter wants it." He told her that the daughter thought she would benefit from having someone to talk with about her frustrations with the facility and not liking the food or being able to go where she wanted and other concerns. Ruth responded: "Hog wash!"

Over the week he learned that Ruth had been a high ranking government employee, a very learned person who loved the theater, read widely and traveled extensively. She had recently undergone cataract surgery in one eye and at this time, could not read. She spoke proudly of her daughter and deceased brother who

committed suicide, which she saw as justified. She spoke rarely of herself except in terms of historical facts. She complained that the daughter never came to see her or had time for her but that she loved her. Many times concerning her daughter, Ruth would say: "She is busy, busy, busy and I am supposed to be happy, happy, happy."

Only at times did she speak of her own misery, such as, how bad the food was or that she could not spend her own money. The daughter would tell her that she was extravagant, would run out of money, and then wouldn't have that marvelous facility, which Ruth did not like anyway.

Ruth felt that she was at the daughter's mercy. How ironic, she thought, that she had cared for the daughter but now she was cared for by that same daughter. Likewise, she did not control her own checkbook, had no car at her disposal, and though she had her own bed, it was not in her own house or even her daughter's house. She had her own room but not even her jewelry because it was not safe there.

The daughter made all of her decisions except whom she called on the telephone. She complained often that the daughter never came to see her. She would always ask the counselor if he had seen or talked to the daughter. She never got past thinking that he was the daughter's agent who reported on her. She would regularly ask if he felt she needed counseling. From time to time she would have tantrums, and generally act cantankerous. She created problems for all those around her except the counselor.

After the first day, Ruth never again put that wall between them. She talked about her cantankerous behavior. She acted that way on purpose and knew that it irritated her daughter. Ruth would say: "But, you know when I'm like that, she comes to visit."

Ruth would ask him about Bible verses and what they meant. He usually did not know, but he would probe with questions to get her to talk about her brother who committed suicide. She talked about not having a gun or being able to get to the window to break the glass and use it. Sometimes she would talk about the meaning of her life and her sense of futility, but these discussions were short in duration.

The counselor learned that the twinkle in her eyes returned every time they discussed books she had read. She was expansive in her reading and constantly chased him to the dictionary or to the library to research unknowns. At those times the twinkle was there. <u>SHE WAS IN CONTROL</u>.

About the fourth month, she asked: "Do you know why Moses has horns on his head in Michelangelo's painting as he comes down the mountain?" He had never noticed. In one biblical translation it is said, "And the light shone on Moses' head", and Michelangelo took the definition of the words to mean horns. She knew she had him on the run and would ask all sorts of questions for which she had researched the answers. She became a mentor. He allowed this and learned to use it with her. She in turn would allow him to do a little for her. She began to talk a little about the loss of control, that she could not do anything for herself.

Ruth, as most of us, was living in a small room of reality bounded by walls of sensory perception. She was confined by what she could see, hear, feel, and taste. She was experiencing a "capture syndrome". This syndrome is a desire to recapture a dependent relationship with a close associate. It often occurs when there is a decreased discriminatory ability of the person. As Ruth began to lose more of the quality of her life, her decision making power and controls, she wanted to hold tighter and tighter to her daughter who was the one remaining significant person in her life. As most people do, the daughter started moving away from her mother. She could not tolerate the closeness and increased demands for attention especially since they had never been close during their entire lives.

What do you see as the issues for Ruth?

Some issues

Ruth needed and wanted stimulation on her level, about things that were normal for her. As the counselor related to her on that level, she was willing to enter that psychological arena in which she shared her hurts and daily existence. As the pain increased in intensity, Ruth felt more and more anger toward her daughter. As her dependency pulled her toward the daughter, she got angrier when the daughter would not respond. There was a reversal in their relationship. She could not control her daughter as she did in the past, and this lessening of importance in her eyes created a breakdown in the quality of life. To Ruth, no one recognized it, and no one responded to it, most of all the significant person in her life.

What we see with Ruth can be seen in both non-institutional and institutional settings.

Case Three. Fred and Grace had been married about 40 years. The counselor met them when their son was a student in his class.

When the son visited his parents, or they visited him, the son found the atmosphere increasingly uncomfortable. The son found his parents, especially his father, continually nipping at

the heels of his mother. His father had made derogatory comments before but not to this extent or in these circumstances. The relationship was deteriorating. The nipping would occur in the morning, for example, about not being able to find his toothbrush or soap; it would happen at lunch and during the day. It got to the point that very personal statements were made. For example, at supper, for no apparent reason, he would say, "You know, sex isn't what it used to be" or "I don't know what has happened to you, you never used to be like that." In most cases, the mother never responded. When the son could no longer take it, he took his father aside and chastised him for making those statements. He told his father that these were things which he and his mother needed to discuss privately and not at the supper table. The father felt rebuked and distanced himself from his son and from Grace and became embarrassed around his daughter-in-law. They felt him pulling away and thought he was depressed. It became painful for all of the family and they talked with him about seeing a counselor.

What do you see as issues for Fred?

Some issues

1. Fred is problem-focused in that he is attempting to control and change Grace. In his frustrations, he has become angry. He is intently pursuing Grace and as he does, she distances herself from him. This is a pattern which has been characteristic throughout their marriage.

2. There are relationship issues within the marriage and among family members. Interdependence and a sense of belonging is based on shared values. Fred has an inability to express his true feelings in a respectful way. They have differing values and a lack of mutual interests. Thus, frequent disagreements are troublesome areas.

3. Spouse's expectations of each other in older age are important. In this case, emotional qualities are surfacing. Fred and Grace have maintained conformist roles. This continues early sex role divisions into later life.

SUMMARY

All three cases share some things in common in a relationship. Each relationship has taken on a different meaning. Dependency, control and loss can be seen in all of them. It is helpful to identify one's own issues around aging, how they make you feel and what they make you want to do. Many times these issues are misinterpreted. If the issues are not

dealt with in an adequate way, they continue to build and foster hostility, anger and deteriorating relationships between couples and between family members. One can benefit from talking about the issues and from understanding what is going on in the areas of control and dependency and associated feelings. Perhaps the issues can be re-framed or re-structured to regain some degree of independence.

RESOURCES:

Atchley, Robert C. (1987). Aging continuity and change. (2nd Ed.). Belmont, CA: Wadsworth.

Counseling the Older Adult: Elements of a Therapeutic Counseling Environment. (Figure 14).

Elements of a Therapeutic Counseling Relationship: Counseling the Older Adult. (Figure 15).

Figure 14.

Counseling the Older Adult:
Elements of Therapeutic Counseling Environment

A. Helpful Communication Behavior With the Hearing Impaired Client

1. Speak clearly, slowly, in good lighting and face the person directly. Do not shout, as shouting distorts your voice tone and facial expression.

2. Be sure to get the person's attention before speaking. Do not start to speak abruptly.

3. Do not cover your mouth when speaking, or smoke or chew gum. This distorts your voice and makes lip reading difficult.

4. Lower the pitch of your voice. Also telephone bells, door bells, horns and emergency alarms need to be low-toned.

5. Repeat what you have said using different words.

6. Know which ear the person has least difficulty in hearing from and always speak to that side.

7. Keep the counseling room free of extraneous background noises as much as possible, such as radios, air conditioning.

8. If the client has a hearing aid that appears not to be functioning correctly, check to see if the microphone portion of the instrument has inadvertently been covered up or not turned up sufficiently.

9. When a person is completely deaf, use written communication, writing clearly in large letters. Keep a large pad and black felt tip pen (for writing in bold letters) nearby.

10. Let the person know that his problem is common with aging and that he can help himself by helping others to be better speakers.

11. Encourage hearing impaired clients to learn to lip read. Be aware, however, of the following problems which make lip reading difficult:

    a. One third of all sounds and syllables cannot be seen on the lips when spoken;

b. About 50 percent of English words are homophonous; that is, they look alike on the lips. Examples; may, pay, and bay;

c. Impaired eyesight on the part of the lip reader;

d. Poor speech movements on the part of the speaker;

e. Exaggerated and distorted speech movements by people trying to help the lip reader;

f. Speech which is too rapid;

g. The amount, direction and type of lighting on the speaker's face;

h. Moustaches which cover the lip;

i. Anything such as cigars, pencils, fingers, food or gum in or covering the speaker's mouth.

B. Helpful Environmental Adaptations

1. Provide adequate lighting at all times but avoid bright glare.

2. Avoid highly polished floors which may be slippery and scatter rugs that are not tacked down.

3. If there is a phone available for client's use, have it equipped with a special dial that has enlarged numbers or volume regulation.

4. Have large clocks and calendars in the office which are more readable or provide orientation.

5. Have an office setting that has few or no steps that the client has to negotiate.

6. If it is known that the client has difficulty with mobility, be sure she/he has assistance in negotiating the entrance to the building and any stairs. Ramps are most accommodating but not always practical in a small, private office.

7. Provide a firm chair with a straight back for the client. Soft deep-seated chairs are not as comfortable for clients with back pain. Deep-seated chairs are difficult for many older clients to maneuver in and out of because of decreased muscular strength and control in the smaller muscles of the legs.

8. Allow clients with rheumatoid disease freedom to move about frequently, as sitting in one position for long periods may be uncomfortable if not painful.

9. Provide a room temperature that is well within the comfort zone for warmth as older adults are more prone to feeling cold because of decreased fat beneath the skin. An uncomfortably cold room temperature may be a distracting factor that can effectively hinder the communication process.

Information in this section is adapted from the following handouts or books:

"Introduction to Lip Reading," a handout developed by the University of Michigan Audiology and Speech Clinic.

Maciane, Alberta. (1979). "Physiological changes and common health problems of aging", in Counseling the aged, American Personnel and Guidance Association.

"Simple Courtesy and the Hard of Hearing," a bulletin from the Detroit Hearing Center.

Figure 15.

Elements of a Therapeutic Counseling Relationship
Counseling the Older Adult

A. Needs to be mindful in relating to others:

1. The need for affection and an opportunity to express affection.
2. The need to be respected for their competence.
3. The need for continued concrete, specific information for immediate issues, decision-making and dignity.
4. The need for advocacy to offset oppressive institutions.
5. The need for continued stimulation to challenge involvement and participation in the environment.
6. The need to feel useful.
7. The need to continue a growth pattern toward their highest potential.
8. The need to relate to their spiritual value.
9. The need to create a sense of accomplishment.
10. The need to direct and control their own existence.
11. The need to feel a part of something, a sense of security, and something to hope for.

B. Counselor attention to the older adult

1. To come to terms with one's own feelings about the aging process.
2. To assist the older adult to as much independence as is desired or possible.
3. Assist the older adult to organize his/her life on what he/she has to offer in terms of what he/she has lost.
4. Recognize that grief work is ever more present and important in aging.
5. Recognize that companionship is vital especially friendships along with gender differences.
6. Become a reality check for those who are questioning

what is normal or what is possible.

7. Be cognizant of rituals which are important to the family of origin and provide outlets for this type of caring.

8. Recognize spiritual needs as requested and integrate through intervention or comfortable involvement.

9. Recognize that social change is still a consciousness raising activity involving assessment, skill building and advocacy help for the older adult.

10. Recognize the counselor attitudes, myths, stereotypes, misinformation, cultural insensitivity and noninvolvement which projects a negative attitude in growing older.

11. Recognize the losses associated with physical, psychological and sociological dimensions of aging.

12. Recognize stress areas commonly experienced by the older adult.

FACING THE OPTIONS
THE TRANSITION TOWARD INSTITUTIONAL CARE

Mary Kendrick Moore, M.Div

and

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> I am 68 years old and I have some decisions to make. It's hard for me to say that. I don't want to think that I'm getting older. My husband died five years ago and my sons want me to move to Florida to be near them. I sew part time in my home and they say I can sew just as well there. I've always thought when I needed help I would move into a retirement community in Atlanta. If I do that, do you think I could still sew for a little extra income?
>
> I have so many books and records that I don't think I can part with. How much room will there be in the apartments?
>
> All of these things are such an emotional part of my life, yet to anybody else they would be junk. I like privacy too...is there any privacy?
>
> I'm just afraid of selling my little house and moving to Florida. What if I want to come back? Yet, you know...Florida would be good for my arthritis.

The decisions persons face as they consider options for their later years are many. The struggle may be intense. The pain of grief can be immense. The search for integrity, independence, and hope is often strong.

"For the first time in American history, the average married couple, by the time they are 40 years old, has more parents than children," reports Samuel H. Preston, sociologist at the University of Pennsylvania.[1] Every day more than 5,000 people in this country turn age 65. Chronic disability in this fastest growing segment of our population will require one in five Americans to seek some form of long term care. For every person who spends some time in an institution before their death, another two or three persons have the same or greater needs in their home.[2]

Clergy and agency staff who work in the field of aging will hear the concerns, fears, and hopes of the older person and their caregivers as they make decisions. You, as persons knowledgeable about aging, will help build bridges for a smoother transition toward a future for older persons which may include institutionalization.

THE MOVE TOWARD INSTITUTIONAL CARE

Important for work with older persons is not underestimating the impact of the decisions they and their families make when the need for services of an institution arises. Institutional settings for the older person range from residential facilities for independent living, to intermediate and skilled nursing homes for both short and long term care, to personal care homes, and adult day care. The feelings about institutional services may also be generated when nursing care is needed in one's home, prior to an actual decision to move. What then is the responsibility of the clergy and agency staff to older persons and their families as the need for institutional care becomes evident? The basic question is, "Why get involved?"

All moves and changes are not equal. There are many factors that contribute to the context of a move and should be noted. A move for an older person has qualities similar to other moves a person may have made during his/her lifetime. Factors affecting one's ability to adjust include:

1. Lifelong Patterns of Coping

   An older person's ability to cope follows the patterns of their past. Someone with a history of intense anxiety in response to change will likely follow a similar pattern during a move to an institutional setting. For example, a woman who has lived in one home on a farm all her life will cope very differently than an older person who has moved frequently.

2. Factors Necessitating the Change

   The response is different if the person needs long term care due to a sudden stroke rather than to gradual physical decline.

3. Participation in the Decision-Making

   Adjustment may happen in direct correlation with how the older person participates in the decision. For example, an older woman whose family members decided she needed to live in a high rise for the older person and who picked out her apartment, has the same impact as the

experience of a spouse who pulls into the driveway in Georgia and says; "Darling, I was offered a position in Pennsylvania today and I accepted it. I know you'll love it there!"

Old age does not render a person incapable of decision making. The process goes on for the older person as it does for others. The issues are often more intense as related by one older woman considering a change:

> It's almost as if I have to give up myself and make the same decisions for myself that my son would make if I were to die. I've got decisions to make...I am not going to be 45 years old again.

Decisions must be treated sensitively and at the capability level of each person. For example, one older person may choose his/her own apartment while an Alzheimer's patient may only be capable of deciding the color of clothing to wear that day.

THE INSTITUTION: A SPARK FOR GRIEF

Relocation to an institutional setting, whether for sheltered but independent living or for skilled care, can evoke many emotional responses. Although older persons cope with change and loss continually, relocation to an institutional setting may draw on many of one's personal resources for coping. Such a move may trigger resistance, depression, disorientation or other personal dynamics often termed "relocation trauma". Sometimes the move may be compounded by the loss of a spouse, close friend, family member or a change in health or financial status. Questions often asked at this time reflect social isolation, grief and a loss of identity: "How can I go on this way?", "Will I ever adjust?" The person may begin to feel like a non-being, as if they are no longer who they have been.

At a deep emotional and spiritual level, the move to an institution often initiates questions about the meaning of life and questions about the timing and circumstances of one's death. The question with which the older person now wrestles is "Has life been meaningful?" This process sparks memories and life stories that may be thought of as rearranging things on the shelves of one's mind. This process can be rewarding and bring a sense of fulfillment. It can also be quite painful when grief is unresolved and the older person begins to conclude that, in fact, life has not been meaningful. At risk here is any hope for continued living. Depression often accompanies this life review process and warrants that professional psychiatric help be sought. The most common of all mental illnesses, depression, is four times more prevalent among older persons than in the general

population.[3] Though 80% to 90% of persons suffering from depression can be effectively treated, many persons deny the symptoms or accept them as a normal part of aging.[4] Keys to health here are alert clergy, agency staff persons and family members who identify the symptoms of depression before hope diminishes.

Many practical issues also complicate the decision to seek institutional care. Older persons and families are faced with selling houses, giving up furniture, and applying for financial assistance. The questions, "How can I give up my home?", "How can I give up my pet?" and "What is the best decision to meet my needs?" are ones that embody a sense of grief and fear. The physical loss of home or personal belongings or financial control symbolizes for the older person a loss of security. Even an active older woman who looks forward to a move to the retirement community experiences grief over giving up treasured pieces of furniture which her new apartment will not accommodate. With the tangible loss comes a feeling that the security and comfort her move afforded her is threatened.

Relocation to an institutional setting often reflects the most feared loss of the older person: the loss of independence, the loss of ability to make it on one's own any longer. The quality of life at stake is loss of the sense of one's integrity. Maintaining integrity depends upon the person having responsibility for his/her decisions about life as long as possible, in whatever ways are possible. That may mean providing options concerning ways to manage money and make final decisions. It may mean letting them choose whether to walk down the hall or ride in a wheelchair. Maintaining integrity for the older person means that we do not assume they are helpless.

The life issues with which all of us struggle throughout the life course, the need for belonging, meaning, security, and identity, continue for older persons until death whether in or out of an institutional setting. A "given" for clergy and agency staff involved with older persons families considering an institution is that grief <u>will</u> be part of the experience, whether expressed or denied, or whether intense or mild. Grief may begin prior to the process of entering an institution, or one may begin to grieve when the actual physical change takes place. Or the grief may not surface until weeks or months later. Giving the older person the opportunity to talk about the transition and their losses may give them the hope to call the new place "home."

THE ROLE OF THE CLERGY AND AGENCY STAFF

For clergy and agency staff in the field of aging, roles take on many characteristics. The <u>nurturer</u> supports the older person and family members through crises and the transition,

hearing the intense emotions that are present and allowing their expression. As transition sparks a life review process, people often simply need a witness to their struggle. A caring heart and a listening ear may make a difference to the older person who has begun to feel "No one cares."

The clergy and agency staff as a guide functions much like a tour guide, providing a summary of what is available. Many older persons make a rapid decision without considering their options or even knowing they exist. Our responsibility is to let them know they have options and walk them through their choices without deciding for them.

The clergy and aging staff are not the decision makers. Options and opportunities are presented, and as facilitators they allow the older person and their caregiver or family members to make the decisions. Facilitating participation in the decision making process will impact the sense of integrity the person has for living out his/her life. For the independent older person, this means deciding to visit the facilities and choosing the environment in which he/she will live. For the older person moving to a nursing home, it may mean choosing the photographs that will go on the nightstand.

And finally as advocate, the clergy and agency staff speaks on behalf of the well being of the older person to the other persons involved in his/her case. This "speaking for" extends to the family, the institutions, the community, and the government, and is particularly crucial in instances where the physical and mental health of the older person is at stake.

A WORD ABOUT WELLNESS IN INSTITUTIONAL SETTINGS

Most persons who consider life in an institutional setting have begun to experience some degree of physical or mental decline. Important to note though is that the older person often has the impression that wellness describes his/her ability to perform daily routine tasks rather than the absence of physical aliments. The older person (and the family) may enhance wellness through any means that will keep body and mind in a healthy state. It is true that a fit body improves one's state of mind. The reverse is also true and becomes a key consideration for the health of the older person and the caregivers. A healthy state of mind improves one's health.

Stress causes high blood pressure, ulcers, a loss of or increase in appetite, rheumatoid arthritis, asthma, an overactive thyroid, and a host of other physical symptoms. In extreme cases, it contributes to heart disease. For older persons, a move to institutional care produces stress which can be critical to health and increases further the significance of helping them

prepare for and adjust to changes. For family members, positive coping with stress helps them assure that their own health will be maintained, thus increasing an ability to communicate more openly and effectively.

The attention of many persons in the social network of clergy, church friends, agency staff and family members to these issues will assure more support for the older person as he/she copes with decisions and changes. Life transition does not happen as a neatly tied package to be given as a gift. Quite to the contrary, it accompanies the older person on his/her visit to the physician and on the next family visit. It spills over into conversation with a clergy person, and over a cup of tea at a bridge party, and travels to the ears of the activities coordinator at the Senior Center where he/she visits twice a week to do ceramics.

We might consider that the primary goal of the work of clergy and agency staff is to enable a sense of wellness in the midst of difficult transition made more complex by an interlocking mass of issues, decisions, relationships and resources.

CASE PRESENTATIONS FOR DISCUSSION

Case 1. For the past 20 years, Mrs. P. had made her home on the mid-Atlantic coast. Although she was widowed about 10 years ago, she appeared to be managing quite independently. As Mrs. P. approached her 85th birthday, her son, an only child, began discussing the possibility of Mrs. P. moving to Atlanta to be closer to him for convenience. In mutual agreement an apartment was leased in a new congregate setting within a few miles of the son's home.

The arrangements were finalized and the week prior to occupying her new apartment Mrs. P. stayed at the son's home. During that week, Mrs. P. had difficulty taking her medication on time or taking proper dosages, could not always find her way to the bathroom, and frequently confused meal times.

The son and his wife attempted to discuss some of these observations, but Mrs. P. became quite adamant that she was still capable of being very independent, or perceived that the only viable options for her were the leased apartment or to remain in the son's home.

During the six months of decision making regarding the move to Atlanta, the son experienced two significant events:

1. His career as an airline pilot was disrupted by a labor

dispute and strike with no resolution in the near future;

2. He remarried and brought a new wife with teenage step-children into his home.

Case 2. Mrs. Jones moved her mother into her home after Mr. Jones died and she discovered that her mother was not eating properly or taking care of her personal hygiene. Mother was not involved in the process but made the initial move with little disagreement. Once in the home she began to disrupt the couple's schedule. Each time the couple would leave for a social appointment, she would have a crisis and call them home.

After two years the son-in-law made the decision that it would be better for her to move into a nursing home, or he would move out.

The daughter could not bring herself to tell her mother of this decision until the day of the move. It was never discussed. The son-in-law got mother into the car but when they arrived at the front door of the nursing home, he could not physically remove her from the back seat. She wedged her frail body of 80 pounds in the back and no amount of strength could budge her.

After 2-1/2 hours of coaxing, she came out to the curb. The next 5 hours were spent sitting on the edge of the road with a social worker attempting to work through her feelings and those of her son.

The next six weeks were a nightmare. Mother screamed, refused to eat, was abusive to the staff and her roommate, and called her daughter night and day. The staff asked the daughter not to visit for two weeks due to the behavior of her mother.

Questions to Consider

1. What are the issues here? What is at stake for the older person making the decision?

2. What is the person feeling? If it is difficult to determine, then imagine what you would feel if you were in the situation, or if it were your own parent.

3. What are the family and community resources available to the older person?

4. What are the family communication patterns present and how can you facilitate more effective communication?

5. What options appear to be in the best interest of the older person?

6. What fears, attitudes and feelings may be blocking the person's or family's ability to make a decision?

7. What is the task of the clergy and agency staff with this person or family?

RESOURCES:

For interpreting some of these issues programmatically, See Chapter seven of:

Tobin, S., Ellor, J.W. & Anderson-Ray, S.M. (1986). Enabling the elderly. Albany, NY: State University of New York Press.

ENDNOTES

1. Simon, C. (April, 1989). A care package. Psychology Today.

2. "Consumer Notes" published by The American Council of Lie Insurance and "A Guide to Long Term Care Insurance" published by The American Association of Retired Persons.

3. Gold, M. S. The good news about depression.

4. Pamphlet. (1989). Depression. American Psychiatric Press.

CHAPTER 12. POLICY ISSUES AND THE FUTURE

This section of the curriculum is designed for the final day of training. The purpose is to examine topics not addressed in the other sessions, emerging policy issues and the future of aging.

An area that combines the multiple intent of this section is Biomedical Ethics and Aging. Since 1986 when Daniel Callahan of the Hastings Institute presented his ideas on age based on the rationing of health care, ethicists, policy makers and practitioners have been focusing on a number of issues related to his ideas.

These include policies related to health care services and the allocation of health care, the termination of life by withholding intervention or by medical intervention. Along with passive euthanasia and the Living Will are more basic issues of the termination of life-sustaining technologies, withholding of inventions such as CPR and other protective interventions, and denying transplants to patients based on age not condition or need.

The whole gamut of the rights of the institutionalized elderly are being raised. Are unnecessary restraints being used on the older patient? How are persons of limited cognitive clarity to be treated? Are aging persons with dementia no longer human beings worthy of social investment? Is there growing ageism among the medical professionals so that the personhood of the elderly patient is not taken seriously enough?

The present and future policies on taxation of older persons are related to health care costs as is the issue of intergenerational equity. This is related to one of the most pressing policy issues: retirement income, and the question, "How many public supported pension incomes should a worker receive?"

The growing power of the older population by numbers, voting power, economic resources and skill, contributes to the debate over generational equity and the redistribution of resources. Underneath all of these issues is a single question raised by Stephen Post (1989), are we prepared to respect the dignity and personhood of the aged? Post believes that religious ethicists representing traditions that generally are protective of the elderly need to be involved in this debate. All of the above issues and dilemmas are showing up in new forms of elder abuse as policies, for example the new taxation laws and by news media editorial writers.

Another related issue is how much life is enough? Should efforts be made to continue to solve the problems of aging and

extend life expectancy further? This issue along with the need to be prepared for the "age wave" that is expected to hit between 2000 and 2040 are topics for a final session of the training program.

RESOURCES:

Callahan, Daniel. (1987). Setting limits: Medical care in an aging society. New York: Simon and Schuster.

Cohen, Cynthia B. (Ed.). (1988). Casebook on the termination of life-sustaining treatment and the care of the dying. Bloomington, In.: Indiana University Press.

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ETHICS AND AGING

America's population is an aging one. As such, the problems our society now faces in its dealings with the elderly are bound to become more, rather than less severe. At base, many of these problems involve moral issues. For example:

1. Should society withhold care or expensive medical resources from those who are very old?

2. Is it morally wrong for a grown child to refuse to provide care for his or her aging parents?

3. Does a moral society have a duty to provide care for the elderly?

All of us have opinions on issues such as these; however, in order to understand fully such controversies and to resolve them rationally, some acquaintance with ethical theory is required. The purpose of this topic is to provide a framework for understanding some of the fundamentals of ethics; it provides a framework for informed discussion of those specific moral issues which we shall all have to face as our population grows older.

A background paper on philosophical ethics for the non-philosopher, based on a lecture delivered at the final session of the Atlanta-1989 course, follows the summary outline .

I. Ethics

A. Ethics

Ethics is a discipline involving systematic inquiry into the moral judgments people make and the rules and principles upon which such judgments are based. Ethics and the law are not the same.

B. Types of ethics

1. Descriptive ethics is concerned with facts about the moral judgments or moral beliefs of a person or a group of persons;

2. Normative ethics attempts to provide the means for answering questions of judgment. Its principal purpose is to establish a method for assessing acts as right or wrong; that is to say, normative ethics attempts to develop a theory of right conduct.

II. Ethical Theory

A. Theory of right conduct

B. Moral principle

If we want to find answers to the moral problems that arise in connection with our dealings with the aged, we should proceed as follows:

1. Specify, then critically evaluate the various moral principles that normative ethicists have set forth.

2. Determine which moral principal has the strongest evidential support and use it to formulate a set of moral rules.

3. Using those rules judge individual actions thereby specifying right conduct relative to the elderly.

III. The Challenge of Ethical Relativism

A. Ethical relativism

This asserts that all moral judgments, rules, and principles are relative to particular cultures or individuals, and that consequently, there is no ethical theory that is true in the sense that it is binding on all people in all circumstances.

B. Pros and cons

IV. Moral Theories

Traditionally, broadest classification of moral theories is into one or the other of two classes:

A. Theological

Teleological (or consequentialist) moral theories: the rightness or wrongness of an act is ultimately determined by the act's consequences.

B. Deontological

Deontological (or nonconsequentialist) theories claim that ultimately an act is right or wrong because of some aspect of its character, form or nature.

V. Determination of Best Available Moral Principal (BAMP)

One that is superior to all known alternatives.

A. Reasons for pursuing a BAMP

B. Applications of a BAMP

ETHICS AND AGING

James M. Humber, PhD

INTRODUCTION TO ETHICS

America's population is an aging one. As such, the problems our society now faces in its dealings with the elderly are bound to become more, rather than less severe. At base, many of these problems involve moral issues. For example, should society withhold care or expensive medical resources from those who are very old? Is it morally wrong for a grown child to refuse to provide care for his or her aging parents? Does a moral society have a duty to provide care for the elderly? All of us have opinions on issues such as these; however, in order to understand fully such controversies and to resolve them rationally, some acquaintance with ethical theory is required. This introduction presents some of the fundamentals of ethics; it provides a framework for informed discussion of those specific moral issues which we shall all have to face as our population grows older.

Ethics is a discipline involving systematic inquiry into the moral judgments people make and the rules and principles upon which such judgments are based. One must be careful not to confuse ethics and legal studies; for although both fields of inquiry are concerned with judgments of right and wrong, what is legally right and wrong need not conform to what is morally right and wrong, and vice-versa. For example, most would agree that lying is almost always morally wrong; however, such action is not illegal. Similarly, until very recently in our society, segregation was mandated by many states' laws. Thus, any Black who sat in the front of the bus in the South in 1940 did something legally wrong; still, he or she did not do anything morally wrong.[1]

Having defined ethics and taken note of the distinction between ethics and the law, we should note that there are two major types of ethics: descriptive ethics and normative ethics. The former is concerned with facts about the moral judgments or moral beliefs of a person or a group of persons; for example:

1. Mary Doe believes that she would act in a morally wrong way if she were to refuse to provide care for her elderly and infirm mother.

2. Most Americans believe that society would be wrong to deny persons over 55 years of age free dialysis treatment.

These are factful claims, the truth or falsity of which is determinable by empirical investigation. Research of this sort

is conducted by social scientists, and not by ethicists. Thus, to find whether number 1 is true or false, we need only ask Doe's opinion. Similarly, we can determine the truth or falsity of number 2 by polling a large, representative sample of the American people. If the sample indicates that most believe that it would be wrong to deny free dialysis therapy to those over 55, we can then justifiably infer that number 2 is true.

Assertions 1 and 2 are not moral judgments; rather, they are factual claims about the moral judgments that people make. Since descriptive ethics is concerned with these factual claims, and not with moral judgments proper, it does not resolve the moral issues we must face when dealing with the elderly. For example, most Americans may <u>believe</u> that it is morally right for our society to provide free dialysis treatment for persons over 55 years of age. However, if this is so, it does not follow that it <u>is</u> morally right for our society to provide such treatment. After all, most ancient Greeks thought that slavery was morally proper, but this does not mean that slavery was a moral activity in ancient Greece.

We have seen that descriptive ethics only tells us what persons or groups believe concerning moral matters, and that consequently, this discipline cannot establish the truth or falsity of moral judgments as, "It is right for society to provide free dialysis treatments to persons over 55 years of age." If this is true, however, how are we to determine what is right conduct relative to the aged and infirm? Normative ethics attempts to provide the means for answering this question, for its principal purpose is to establish a method for assessing acts as right or wrong; that is to say, normative ethics attempts to develop a theory of right conduct.

Let us call a theory of right conduct an <u>ethical theory</u>. To illustrate what an ethical theory is, and to show how such a theory operates to validate specific moral judgments, consider the following case. Let us assume that an elderly woman (W) is in a coma after having suffered a series of heart attacks. Doctors at the hospital where W is maintained agree that W will never recover; however, she could live for weeks, or perhaps months, if all possible measures are taken to keep her alive. Given these conditions, W's doctors ask W's two adult sons (J and B) whether they should do everything in their power to resuscitate W should she again go into cardiac arrest. The conversation between J and B goes as follows:

> B1: So far as I am concerned, telling the doctors not to do everything to keep Mom alive is the same as telling them to kill her. I accept the Ten Commandments, and one of these says that it is wrong to kill. Thus, I think we should tell the doctors to keep Mom alive as long as possible.

J1: I'm sorry, but I think you're wrong. I don't see why we ought unquestioningly to accept the Ten Commandments; furthermore, in this situation I think the rule we ought to follow is that when we know someone will not recover from a coma, we should not use heroic lifesaving measures.

B2: Whether you like it or not brother, you have to accept the Ten Commandments. These commandments define morally right action because they express the will of God and God is the moral lawgiver.

J2: I'm not sure there is a God. So far as I'm concerned, we ought to tell the doctors to refrain from making every effort to save Mom because this action will produce the best consequences for everyone. After all, to drag out the process of Mom's dying will only drain our financial resources, hurt Mom's insurance company, impose burdens upon the hospital, and do nothing to benefit Mom.

Given our present purposes we need not extend this argument to determine who is right. What is noteworthy about the exchange is how one usually goes about justifying moral judgments. Ordinarily, moral disagreements occur within a context of action, and what one judges are acts, (In the case at hand, the action that is being judged concerns the instructions to be given W's doctors.) When a person judges an act he/she usually appeals to some moral rule to justify his or her moral judgment. (B1 and J1 both involve appeals to moral rules; in B1 the rule is, "it is wrong to kill," and in J1 the rule is, "we should not use heroic measures to keep alive a person who will never recover from a coma.") Unfortunately, appeals to rules do not invariably settle moral disputes because, as B1 and J1 illustrate, moral rules may differ, and if two people accept different moral rules their moral judgments may differ. To fully justify one's moral judgments, then, a person must show why his moral rules are correct while his adversary's are not. To accomplish this a person appeals to a more general rule, a moral principle or standard. In the above discussion, B2 contains an appeal to the principal that God's will determines which rules delineate right conduct, while J2 appeals to the principle that a moral rule is correct if following the rule will produce the best consequences for everyone.

For the purposes of this essay, let us say that an ethical theory is a set of moral rules justified by an appeal to a moral principal.[2] If a person has an ethical theory, he makes moral judgments based on moral rules and then justifies his moral rules

by appealing to a moral principle. In the above discussion, both B and J have ethical theories. Furthermore, our example of the discussion between J and B also indicates that ethical theories differ, and that distinct moral judgments may be based on different rules and principles. To adjudicate this dispute, B and J will have to assess the adequacy of the basic moral principles expressed in B2 and J2. Normative ethics involves the attempt to discover, formulate and define fundamental moral principles.

If we want to find answers to the moral problems that arise in connection with our dealings with the aged, our present discussion indicates that we should proceed as follows: First, we should specify and then critically evaluate the various moral principles that normative ethicists have set forth. Second, after we have determined which moral principle has the strongest evidential support, we should use that principle to formulate a set of moral rules. Finally, using our rules, we can judge individual actions, and in this way specify right conduct relative to the elderly. Before we can even begin such a task, however, we must take up a challenge to our proposed procedure; the challenge is known as ethical relativism (ER).

Ethical relativism asserts that all moral judgments, rules, and principles are relative to particular cultures or individuals, and that consequently, there is no ethical theory that is true in the sense that it is binding on all people in all circumstances. If this claim is correct, it would appear that we should not waste our time critically evaluating moral principles, for none of these principles can be shown to be true or universally applicable. That is to say, the procedure we have outlined for resolving moral disputes seems to presuppose that there is a true moral principle and that we can discover this principle much as we would discover the answer to a difficult mathematical problem. However, if ER is correct, there is no true moral principle awaiting our "discovery," and our proposed procedure for resolving moral disputes is misguided.

The first thing to be said about ER is that the arguments which usually are offered in support of the position do not force one to conclude that ER is true. Basically, these arguments are of two sorts. First, relativists assert that we do not have the ability to prove any moral principle true, and that this indicates that there is no universally applicable moral principle. Second, relativists point out that: (a) different societies appear to accept different ethical theories (e.g., although most of Iran's citizens accept an Islamic moral code, this is not true of Ireland's populace), and (b) different individuals often accept different moral theories (e.g., in our earlier example, B and J appeal to alternate theories). Relativists claim that this shows that ethical theories are "true" relative to cultures or individuals, and hence that there

is no ethical principle that is binding on all people in all circumstances. It does not take a great deal of thought to see that both of the above arguments fall short of proving ER true. Admittedly, we do not presently have the ability to demonstrate that any moral principle is true, or binding on all people at all times. However, this does not prove that there is no true moral principle. After all, there was a time when we could not demonstrate that the earth was round; this did not show that the earth's shape could only be determined relative to different cultures' beliefs, or that the earth had no determinate shape. Similarly, the fact that different cultures and individuals accept different moral principles does not show that there is no moral principle which is binding on everyone, in all circumstances. If ten people are given a difficult math problem to solve, and each derives a different answer, this does not prove that there is no correct answer to the problem.

We have seen that ER lacks strong support. In point of fact, however, the case against ER is much stronger than this, for there are at least two good reasons to reject ER. First, acceptance of ER seems to force us to conclude that either: (a) it is possible that no one ever does anything morally wrong, or (b) it is impossible for us to judge actions morally. To see why this is so, let us assume that ER is true. In this case, how could we morally judge an individual's actions? Since relativists insist that no one can prove that his/her moral theory is true or universally binding, relativists must admit that no one has a rational justification for using his/her <u>own</u> theory to judge others' actions. If we admit this, however, should we judge each person's actions by the moral theory which that person professes to accept? This seems problematic, for if we were to proceed in this fashion each person could claim to accept a moral theory which "validated" his/her actions, and showed them to be right. If this were to occur, we would have to allow that no one ever acted wrongly, and this seems absurd. On the other hand, some relativists claim that we should judge all individuals in a given society (S) by appealing to the moral theory (MT) which is accepted by most of S's citizens. However, the fact that the majority in S accepts MT does not show that MT is true and, therefore, binding on all citizens of S. Thus, we have no rational justification for using MT to judge those individuals in S who do not accept MT. How, then are we to judge these citizens of S? Should we use the moral theory (or theories) which these people profess to accept? If so, we are once again judging each individual by the moral theory he/she claims to accept, and must once again allow for the possibility that no one ever acts wrongly. Furthermore, it should be clear that relativists cannot escape this conclusion by arguing that although no ethical theory is true, it nevertheless is morally right to judge all individuals by whatever moral theory is accepted by most people in their society. A moral claim of this sort is universal in scope, and relativists deny that there are

any moral assertions that are universally binding. In the end, then, ER seems either to lead to the conclusion that moral judgment is impossible, or to the view that it is possible that everyone always act morally. Those who find these conclusions dissatisfying have good reason to reject ER.

Apart from the above, there is a second reason to reject ER. We have seen that there are two possible versions of ER; one version takes ethical judgments, rules and principles to be relative to individuals, while the other version takes these things to be relative to cultures or societies. If the first version of ER is correct, we cannot say that one person's moral theory is better than another's, but only that theory #1 is true for person #1, theory #2 is true for person #2. Similarly, if the second version of ER is true we cannot say that one culture's moral theory is better or worse than another's, but only that different cultures accept different moral theories as true. However, there is good reason to believe that we can discriminate between better and worse moral theories. For example, let us assume that a person (P) accepts a moral principle that differs from my own, and that P's principle leads to the conclusion that it is morally proper for P to mutilate babies whenever P desires. Assuming that my moral principle does not lead to such a moral judgment, it seems obvious that I have good reason to assert that my theory is superior to P's. Furthermore, this holds true, even though I cannot demonstrate that my moral principle is true in the sense that it is binding on all people in all circumstances. Similar considerations also apply to cultural ER. For example, if cultural ER is true we have no justification whatsoever for saying that the morality of a Christian society is superior to that of a Nazi culture. However, even if we cannot prove that Christian morality is true or universally binding, it seems clear that we have good reason to believe that this moral theory is superior to Nazism.[3]

Our discussion thus far indicates that we have strong grounds for rejecting ER; hence, ER does not undercut our attempt to discover a universally applicable moral principle. But if this is so, how are we to proceed in our quest? Given the present state of our knowledge, we cannot demonstrate that any moral principle is true, or applicable to everyone in all circumstances. However, we can assess the strengths and weaknesses of various moral principles, and in this way determine the best available candidate for the role of universal moral principle. To illustrate how this process of evaluation occurs, it will be useful to analyze four different moral theories. These moral theories are not the only ones available for use in making moral judgments. However, they represent the major traditions in normative ethical theory, and examining them will provide the reader with the critical tools necessary to assess the strengths and weaknesses of alternative theories.

Before we begin to analyze any of the four theories that shall serve as the focus of our discussion, we should note that many moral theories have characteristics in common. The existence of these shared traits allows for the classification of ethical theories into specific types. Classification of this sort is helpful because theories of the same sort often exhibit similar strengths and weaknesses; hence, knowing what class a moral theory belongs to can be very useful in critically evaluating that theory.

Traditionally, the broadest classification of moral theories is into one or the other of two classes: (1) teleological (or consequentialist) moral theories, and (2) deontological (or nonconsequentialist) theories. Teleological theories hold that the rightness or wrongness of an act is ultimately determined by the act's consequences; i.e., an act is said to be morally right if it produces good consequences, and wrong if it produces bad results. Deontologists reject this view and claim that ultimately an act is right or wrong because of some aspect of its character, form, or nature. In addition, most deontologists insist that an action cannot be judged morally unless one knows why the person who performed the action did what he did. In other words, deontologists tell us that a person's motives for acting are important, and that an action cannot be morally right unless the person (the agent) who performed it did what he did for the right reasons.

In what follows, we shall discuss two teleological moral theories and two deontological theories. We shall begin with an examination of the teleological theories.

Teleology: Act Utilitarianism and Rule Utilitarianism

According to the act utilitarian, an act is morally right if and only if it maximizes utility, that is, if and only if the ratio of benefit to harm calculated by taking everyone affected by the act into consideration is greater than the ratio of benefit to harm resulting from any alternative act. In deciding to act, then, the act utilitarian will first set out the alternatives open to him. Second, he calculates the ratio of benefit to harm for each individual, including himself, affected by the alternative acts. Third, he adds up the ratios for each alternative act. Finally, he chooses the act that results in the greatest total ratio of benefit to harm. Assume, for example, that there are three alternative acts (A_1, A_2, A_3) open to person P_1, and that there are three people (P_1, P_2, P_3) affected by each alternative act. Assume, furthermore, that the ratio of benefit to harm for each person affected by each act can be expressed quantitatively, with a plus value indicating a benefit and a negative value indicating a harmful effect. Finally, assume a calculation yields the following result:

	P_1	P_2	P_3	Totals
A_1	+4	-5	+8	+7
A_2	+6	+2	-3	+5
A_3	-2	-5	+4	-3

In this situation the act utilitarian will choose act A_1 because it produces the greatest ratio of benefit to harm (+7) when everyone affected by the act is taken into consideration.

The moral principle of act utilitarianism states that an act is morally right if and only if it maximizes utility. Act utilitarians use this principle to directly judge individual actions; hence, act utilitarianism is an ethical theory that does not appeal to moral rules to judge behavior. At first glance it may appear that act utilitarianism's lack of moral rules is a strength. After all, no two actions are exactly the same, and it seems that this fact ought to be taken into account, when we morally judge different actions; however, if we judge actions by appealing to moral rules, it is not clear that we do take this fact into account. To see why this is so, consider the following two cases.

Case 1. Let us say that my wife is wearing a new dress that she is quite proud of, and she asks me whether I like it. I do not care for the dress, but lie, and in so doing make my wife feel good. Case 2. Once again my wife is wearing a new dress, and she asks for my opinion of it. This time I like the dress, but I tell her I hate it; this causes her to feel pain. Now, both case #1 and case #2 are examples of lying. Furthermore, if we were to judge the actions in these cases by referring to the commonly accepted moral rule, "It is wrong to lie," both actions would be morally wrong. However, many people would want to claim that the lie in case #1 is not wrong. Why is this so? The answer seems clear enough: the lie in case #1 has good consequences for everyone involved (i.e., the lie maximized utility), while the lie in case #2 produced harm. Hence, the lie in case #1 and the lie in case #2 differ in a morally significant way. Act utilitarianism takes note of this difference; it tells us that the lie in case #2 is wrong because it produced bad consequences overall, but that the lie in case #1 is morally justified because it produced good consequences for everyone concerned. On the other hand, ethical theories that make moral judgments by slavishly appealing to moral rules ignore differences of this sort, and in so doing, they sometimes produce moral judgments that violate our basic moral intuitions. Thus, act utilitarians can argue that their moral theory is superior to rule-oriented theories, because their theory possesses a sensitivity to detail that rule-bound theories lack.

When act utilitarians tell us that it is a mistake to obey moral rules unquestioningly, and when they insist that those who engage in moral judgment must remain sensitive to the fact that

no two actions are exactly the same, they are on strong ground. However, when act utilitarians exclude all moral rules from their ethical theory, they go beyond these assertions, and effectively deny that moral rules play any part in moral judgment. This is a radical position, and demonstrably false. For example, let us say that one of the principle concerns of a husband and wife (H and W) is that they be properly cared for in their old age. Over the years, H and W put away a great deal of money for their retirement. Furthermore, the couple examines a number of nursing homes and agrees that should either of them require nursing home care, each would want to be housed in a very expensive facility (F). This being the case, H and W enter into an agreement: should either partner require care in a nursing home, the remaining spouse will use money from their ample retirement account to pay for the person to be housed in F. To "seal" the agreement, both H and W vow, or solemnly promise, to abide by the terms of their agreement, W becomes ill with Alzheimer's Disease. Eventually, W's condition deteriorates to the point where she is unaware of her surroundings, and care in a nursing home becomes necessary. H reasons that W's state is such that there is no benefit to be derived from housing W in F. W would not know whether she was in F or a much less expensive facility, and if H saved money on W's care he could use the money to maximize utility. Thus, H does not put W in F; rather, he puts her in an inexpensive nursing home. The question, then, is this; Did H act in a morally right way? It appears as though an act utilitarian would have to say yes, but this judgment seems wrong. H violated the moral rule which states that we must keep our promises. For this reason, and for his reason alone, most people would judge that H did something wrong. Furthermore, the specific conditions under which H broke his promise appear irrelevant to our judgement; that is to say, in the case at hand it does not seem to matter that H maximized utility when he broke his promise to W. And if this is so, act utilitarians are wrong when they make no place for moral rules in their ethical theory. Ordinarily, moral rules play a part in our moral considerations, and any moral theory seeking widespread acceptance must take notice of this fact.

Many utilitarians believe that it is possible to avoid criticisms of the sort we have brought against act utilitarians by reformulating the theory so that it makes a place for moral rules. So reformulated, the position is known as rule utilitarianism. According to rule utilitarians, an act A in circumstance C is normally right if and only if the consequences of every one acting on the rule "Do A in C" are better than consequences of everyone acting on any alternative rule. The notion of "best consequences" here is specified in terms of utility maximization. Thus, an act is right if and only if it is in conformity with a particular moral rule, and that rule is chosen because, of all alternative rules, it maximizes utility. For example, a rule utilitarian might claim that "We must keep

our promises" is a proper rule for conduct because if this rule were followed by everyone, it would maximize utility. Using this rule, the rule utilitarian could conclude that in our counter example to act utilitarianism it would be wrong for H to house W in any other nursing home other than F, for to do so would be to break his promise. Since the result seems to accord with our moral intuition, the rule utilitarian contends that his theory represents an advance over act utilitarianism.

Critics of rule utilitarianism, however, point out that if rule utilitarians are committed to the moral rule that maximizes utility, then they will have to allow that the acceptable rule in any case is one that allows exceptions that maximize utility. Thus, instead of the rule, "We must keep our promises," the rule utilitarian must adopt the rule, "We must keep our promises, unless not doing so maximizes utility." In that case, rule utilitarianism collapses into the equivalent of act utilitarianism, and the objection we raised earlier against act utilitarianism resurfaces. For instance, if, in our previous counter example, H were to adopt the moral rule, "We must keep our promises, unless not doing so maximizes utility. "H would be morally justified in breaking his promise to W, because this action maximized utility. Hence, if rule utilitarianism tells us to obey moral rules that allow for exceptions, the position is really no different from act utilitarianism, and suffers from the same shortcomings.

Deontology: Theologism and Kantianism

Theologism asserts that an act is right if, more than any alternative open to the agent at the time, it is the one most consistent with what God wills, either directly or indirectly. Usually, theologism provides us with a set of rules (e.g. the Ten Commandments) thought to express God's will. Whether or not an act is right or wrong, then, is determined in part by reference to these rules. We say that the rightness or wrongness of an action is partially determined by reference to moral rules because most theologians hold that an act may conform to the requirements specified by a legitimate rule of conduct and still not be morally proper. For example, let us say that a person accepts the Ten Commandments as specifying God's will, and refuses to steal when he has an opportunity to do so. In this case, then, he has followed one of God's commandments. But if the individual refused to steal because he was afraid of being caught, or because he wanted to be rewarded in heaven for his good behavior, his action would not be truly right. The motives for action would be "impure," and this impurity would affect (perhaps "infect" is a better word) the moral character of his action. For his action to be truly right, God's command must be followed for the right reason, namely, stealing must be rejected, not out of concern for oneself, but rather out of love for God and fellow men. Given this motive, then, the action would be

right and its subject truly would be deserving of reward in heaven. In short, most versions of theologism hold that God not only wants us to act in certain ways, but also to act in those ways for the right reason.

Kantianism, named for the German philosopher Immanuel Kant (1724-1804), is similar to theologism in a number of ways. Like theologism, Kantianism holds that an action's rightness or wrongness is to be determined by: (1) the action's form or character (i.e., the action must be such that it conforms to certain rules of conduct), and (2) the motives or intentions of the agent. On the other hand, Kantianism differs from theologism in certain significant respects. For one thing, it might well be the case that Kant's moral rules and the rules of theologism differ. The reason this is so is that while theologism justifies its rules by an appeal to God as the moral law-giver, Kant appeals to what he calls the categorical imperative. This principle is an imperative because it is a command. It is categorical because it is a command that holds without qualification. Unfortunately, Kant states the categorical imperative in a variety of different ways. In what follows we shall discuss the two best known formulations.

Sometimes Kant states the categorical imperative as follows: "One ought never to act except in such a way that one can also will that one's maxim should become universal law." Using such a guideline, Kant claims that practices such as lying, killing, stealing, and cheating are all forbidden by the moral law. And the reason they are forbidden is that if these acts were universalized (i.e. if they were practiced by everyone) it no longer would make any sense to speak of such practices occurring. To put it another way, universalization of the practice would destroy the practice itself. For example, consider lying. Unless there is a general context of truth telling, the concept of lying makes no sense, for to lie is not to tell the truth. But if everyone always lied there would be no truth, that is nothing with which lying could be contrasted, and hence no way meaningfully to say that one was lying. On the other hand, the same considerations do not apply to truth telling. If everyone always told the truth it still would make sense to say that people were speaking truly. This is so because "truth" is not defined in terms of "lying," but rather in terms of other criteria, for example, a statement is true if it corresponds with fact.

Using the universalization formulation of the categorical imperative, Kant believes he can derive a set of moral rules that must always be obeyed. In other words, to break one of these rules is always to do something wrong, regardless of particular circumstances in which one acts. On the other hand, simply to act in the ways specified by these rules is not to ensure that one's acts are morally right. Like the theologian, Kant insists

that an action cannot be counted as morally right unless the agent performs the action for the right reason. For Kant, however, one should not act from the motives specified by the theologian. Rather, one must obey moral rules simply because this is the right thing to do. In short, one's motive for action must be respect for the moral law. And when one obeys a rule for this reason, one is doing what is morally right.

Kant's second formulation of the categorical imperative is as follows: "Act so that you treat humanity, whether in your own person or that of another, always as an end and never as a means only." Kant's point here seems to be that all persons deserve respect simply because they are persons. If this principle is accepted everyone has a moral duty to treat others fairly and equitably, to refrain from "using" humans as means for the procurement of one's own or others' ends. In effect, the second statement of the categorical imperative, like the first, leads one to formulate a set of moral rules that must be obeyed if one is to act in morally right ways.

Because Kantianism and theologism are similar, there are criticisms which apply equally to both moral theories. Perhaps the best known criticism applicable to both theories is that they provide us with moral rules that cannot be violated without doing something wrong. Take, for instance, the Kantian injunction against lying. For Kant, lying is always wrong; there are no exceptions to this rule. However, our earlier examples of lying indicate that we do not believe that lying is wrong in all cases. Indeed, given a little time, we can all imagine circumstances in which we ordinarily would say that it was right to lie. Consider the following case: you are walking on a street at night in Germany in 1941, and notice a woman with a Star of David on her coat hiding in a stairwell. As you turn the corner at the end of the block you are stopped by an agent of the Gestapo and asked whether you have seen anyone. Surely in this situation it would be morally right to lie, for to tell the truth would have disastrous consequences. This being the case, we must conclude that there is something wrong with any moral theory that tells us to totally disregard actions' consequences, and to concern ourselves only with obeying pre-established, unbreakable moral rules.

Although Kantianism and theologism are alike, they are also dissimilar in various ways. And because of these dissimilarities there are specific criticisms applicable to each theory. For example, we have seen that Kant states the categorical imperative in a variety of different ways. On the face it, these various formulations do not appear to assert exactly the same things. This being so it is quite likely that different moral rules could be justified, depending upon which formulation of the categorical imperative one happened to accept. But then, which moral rules ought to be accepted? All of them? At first glance this may

sound fine; but what if some of the rules derived from one formulation of the categorical imperative should happen to conflict with rules derived from another formulation? Kantianism gives us no way to resolve a conflict of this sort.

Unlike Kantianism, theologism appeals only to one principle to justify its set of moral rules. Supposedly, the rules of theologism specify right action because these rules, and no others, express God's will. It is at this point, however, that a problem arises. Namely, do the theologians' moral rules express what is right because of God's command, or not? If the theologian says that the rules express what is right because of God's command, two untoward consequences follow. First, it no longer makes any sense to say that God is good. (Since anything God wills is good, for God Himself there is no difference between good and evil; and when we say God is good we assert nothing.) And second, theologians have to admit that if God commanded murder, theft, or cruelty, these actions would be right and morally obligatory. But few people, theologians included, want to admit that actions of this sort ever could be morally right. On the other hand, if the theologians were to claim that their set of moral rules specified right action independently of God's command, then they would have to find a new justification for their moral rules. This is so because the theologians' present position would then be that regardless of what God commands, their set of moral rules specifies right action. And in these circumstances it simply would be contradictory for the theologians to assert that it is because of God's command that their moral rules delineate right conduct.

We have seen that the moral principles which define utilitarianism, theologism and Kantianism are all able to be criticized. Furthermore, these principles are not atypical. That is to say, there are no problem-free moral principles, and this is why we cannot demonstrate with certainty that any one moral principle is true, or binding on all people in all circumstances. Still, if we cannot demonstrate that one ethical principle is true, this does not mean that we should cease in our attempt to find a universally applicable moral principle. After all, our analysis of utilitarianism, Kantianism and theologism shows that we can give evidence in support of, and in opposition to, various moral principles. Thus, it is not unreasonable to suppose that by weighing the evidence for and against competing principles, we might be able to show that one moral principle is better supported than any other known alternative. If we were to succeed in such a task, we would not claim to know that our favored moral principle was true; still, we could claim to know that it was superior to all know competitors. In this case, then, we would be justified in asserting that our principle should be adopted for use by all rational beings. Furthermore, if such acceptance were to come about, moral disagreement would be minimized; for all persons would be appealing to the same

moral theory when they judged actions morally.

Some skeptics will charge that the above procedure for resolving the moral conflicts is misguided, in that it seeks to achieve an unrealizable goal. To support this charge, critics can point to the fact that we do not merely lack the ability to prove one moral principle true, we also lack the ability to show that one ethical principle is better supported than all known competitors. Now it must be admitted that this is true; at present, we cannot show that one moral principle is superior to all known alternatives. (Indeed, it is because this is so that we continue to take utilitarianism, theologism, Kantianism, and various other moral theories seriously.) However, if we cannot presently show that there is one moral principle which is superior to all others, it does not follow that we would be misguided if we were to attempt to find such a principle. In fact, there are at least two reasons to believe that it is worthwhile to pursue such a goal. Let us consider each reason separately.

First, contrary to what skeptics assert, it is reasonable to believe that we someday may be able to formulate a moral principle which is superior to all known alternatives. We presently have the ability to compare moral principles and to show that some are better than others (e.g., we can show that Kantianism is superior to Nazism.) Thus, even at our present stage of moral development, we can eliminate some moral principles from consideration as potential candidates for the role of "best available moral principle" (BAMP). In addition, if we continue to analyze and evaluate those moral principles which cannot be eliminated from consideration as candidates for BAMP, we no doubt shall discover new objections to those principles. If we were to find that a telling objection could be brought against a particular moral principle, and that principle could not be modified so as to avoid the force of that objection, we then would be justified in concluding that the principle was no longer a viable candidate for BAMP. If, on the other hand, the principle could be modified so as to meet the force of the objection, then the principle would be strengthened relative to its competitors. Given enough time, it is not unreasonable to expect that a procedure of this sort would lead to the formulation of a BAMP. At the very least, one must admit that discovery of a BAMP is possible. And if this is so, we must pursue that possibility, for reward to be derived from discovery of a BAMP (viz., reduction in moral conflict) is very great.

The second reason we have for believing that it is worthwhile to seek discovery of a BAMP is this: even if we never succeed in formulating a BAMP, the attempt to discover such a principle provides us with knowledge that is useful in clarifying moral conflicts, resolving moral disputes, and determining right conduct. To see how knowledge which is derived from critical

evaluation of ethical principles can be useful in achieving the above-mentioned goals, consider the following two examples.

(1) Let us say that an adult child (C) has promised to care for his mother (M) in her old age. When the time for care arrives, C tells M that he will not care for her because doing so will inconvenience him. M claims that C's refusal to care for her is wrong; C denies that this is so, and claims that the inconvenience he will suffer justifies his promise-breaking behavior.

Those who have studied normative ethics will have little difficulty resolving the moral conflict illustrated in (1). First, normative ethicists will admit that they have no moral principle which qualifies as BAMP. Nevertheless, they will insist that they have knowledge of a number of well-supported moral principles, and that virtually all of the moral theories defined by these principles hold that one has moral duty to keep his/her promises. At the same time, these theories also allow that it is morally permissible to break a promise <u>when one has an acceptable justification for doing so</u>. In the case at hand, then, the question is this: does C have an acceptable justification for breaking his promise to M? No strongly supported moral theory would claim that C's justification (viz., personal inconvenience) is acceptable. In fact, if we ask whether there are any moral principles which would validate C's justification for breaking his promise to M, only one comes to mind. The principle of egoistic hedonism states that action is morally right if and only if it maximizes pleasure for the agent (i.e., for the person performing the action). If we accept this principle, C is justified in breaking his promise to M in order to avoid personal inconvenience. However, ethicists know that egotistic hedonism is so beset by problems that it must be rejected. This being the case, we can assert that C's justification for his promise-breaking is deficient, and that C does something wrong when he breaks his promise to M. Furthermore, we can claim to know that this judgment is correct, even though we do not have access to BAMP, and cannot demonstrate that there is one moral principle which is true, or universally binding.

(2) Assume that two legislators (L1 and L2) differ on the question of whether the government should provide free dialysis treatment for all persons who are retired, unable to pay for the procedure, and in need of the treatment. When debating the issue, both L1 and L2 use moral arguments to support their views. L1 opposes the procedure. In support of her position, L1 argues that dialysis is expensive, and that the elderly will not live very long, even if given dialysis. Thus, L1 contends that the money that could be spent on dialysis would be better spent elsewhere, for example, on educating the young. In opposition to L1, L2 argues that it is unfair and coldhearted to watch rich

retirees use dialysis, and then condemn poor retirees to death simply because they lack the ability to pay for treatment. Furthermore, L2 argues that the age of retirees should play no part in determining how the government should spend its money. If the government were to use the money that could be spent to maintain the lives of retired persons to educate the young, and the attempt to justify this action by arguing that the young have a greater life-expectancy, the government would be discriminating on the basis of age. And, L2 argues it is wrong to discriminate.

Those familiar with the major traditions in ethics will have little difficulty locating the source of the moral disagreement exhibited in the above example. L1 is a utilitarian; she is arguing that refusing to pay for the retirees' dialysis treatment is justified in terms of utility maximization. On the other hand, L2 accepts some sort of deontological moral theory. In fact, L2's theory contains at least two moral rules; one rule holds that people must be treated equitably or fairly, and the other proscribes discrimination.

Once the source of the disagreement between L1 and L2 is located, it is clear how one must proceed in order to try to resolve the conflict. Two courses of action are possible. First, one could try to show that L1 was wrong in her utility calculations, and that utility would be maximized by providing free dialysis treatment for all poor retirees. Second, one could try to show that L2 has misinterpreted his moral rules, and that when these rules are properly interpreted, it becomes clear that denying free dialysis treatment to retirees is neither unfair nor discriminatory, but validated by some other moral rule that L2 accepts. If either of these ploys were successful, a single course of action would be recommended by both the moral theory of L1 and the moral theory of L2. If both these theories were well-supported, we then would have very strong evidence that the action they recommend was morally proper. This is so because the theories of L1 and L2 represent teleology and deontology respectively, and in general, whenever we have an action judged to be morally proper by well-supported moral theories from <u>both</u> the theological and deontological traditions, we have strong evidence that the judgement is correct.

Finally, it should be obvious that it might be impossible to resolve the moral conflict between L1 and L2. That is to say, L1 might well be correct when she claims that denying free dialysis treatment to retirees maximizes utility, and at the same time, L2 could be right when he insists that such action is both discriminatory and unfair. In this case there would be ultimate moral disagreement between L1 and L2, and if both individuals were unwilling to reject the moral principles which define their ethical theories, they would never agree. How should we respond to such disagreement? For those who have been trained in normative ethics, the answer is clear: we should clarify the

moral principles which define the theories of L1 and L2, and then attempt to determine which of these principles has the strongest evidential support. If the moral theories of both L1 and L2 are well-supported, it would be very difficult to determine which theory was the superior one. In fact, we might very well err in our judgment. However, if we did err, we would have done all that was humanly possible to ensure that our judgment was correct, and this is the most that anyone could expect of us.

Notes

1. The relationship between morality and the law is complex, and the subject of much dispute. For the purpose of this essay we need not inquire into the nature of this relationship, but only note that moral judgments of right and wrong differ from legal judgment.

2. Although most ethical theories have this structure, not all do, for example, some moral theories do not have moral rules.

SECTION III. REPLICATIONS, NETWORKS, CONTINUING EDUCATION

This section is intentionally short. Chapter 13 gives a brief summary of the results of the Statewide Training Model and points toward potential future development. The remainder of this section will be written by many people as the Statewide Training Model is used and expanded and modified. It will be written as graduates of the training receive advanced continuing education training and as new and creative ways of collaborating occur in communities.

The brevity of this section is an invitation for sharing of results as the Statewide Training Model is used.

CHAPTER 13. REPLICATIONS, NETWORKS, CONTINUING EDUCATION

Barbara Thompson, MDiv, MS

The Statewide Training Model delivers a unified Continuing Education Certificate in Gerontology in the field of Religion and Aging. The STM also can be used as a model for non-certificate continuing education training with some modifications of curriculum, length of the course and schedule. However, the tested success of the program centers around the original intent of providing a continuing education certificate.

The Statewide Training Model is designed to serve as a catalyst to mobilize community religious, agency and business resources in new partnerships to serve older persons. Building on this foundation can maintain the interest and momentum of the new networks that have been created. These networks tend to be of at least three sorts.

The first network is that created by the development and work of the statewide and site advisory committees. These committees will have identified a variety of community resource persons and organizations that have made some commitment of human or fiscal resources to the training. As that initial support is nurtured with awareness of the results of the training, continued support of the local collaborative projects and further continuing education training is possible. It may be important to replicate the training in that site as well as in new sites.

The second network is that created in a local area through the relationships and collaborative efforts of the clergy and agency staff participants. There has been evidence from the completed training that new alliances have been formed between some staff of different federal, state and local agencies for greater creativity and expansion of their ongoing work. New cooperative programs have developed between some congregations that could not have existed without breaking barriers between clergy through the training experience. New partnerships between clergy and agency staff have grown into sound and continuing relationships that enhance the outreach of their congregations and agencies to older people.

The third network develops as a result of the Final Session when all of the course participants come together to share the results of their collaborative efforts. Although this network may appear to be nebulous, it is, however, alive and present as participants become aware of the statewide impact on extension of programs and services to older persons their collaborative efforts have made. This experience reinforces commitment to those efforts and lays a foundation for future work.

The graduates of the training become a pool of trained resource persons from which to draw:

1. new state and site advisory committee members;

2. resource persons for additional training;

3. a pool of trained professional persons who need advanced continuing education.

REPLICATIONS

The essential ingredient in the success of replicating the training is development of a sound, working advisory committee. Choice of a skilled gerontology educator and an agency staff person to serve as the Faculty and Site Coordinators would be the first step. Careful identification of key community religious and agency leadership follows, including some professional and business persons with strong lay volunteer or community interest in promoting this training. A group of 15-25 persons is suggested as a good working size.

Development of the advisory committee creates local ownership of the training, effective identification of human and fiscal resources to underwrite the program, knowledge of training needs of participants, curriculum review and suggested modifications of the model. In addition, contacts with and commitments from key agency and religious leaders are important for successful recruitment of a balanced training group.

Often there is a "snowball" effect from graduates of the initial training. Word-of-mouth promotion from agency staff to staff in their own and other communities and from clergy to clergy in judicatory meetings can be a positive recruitment resource. Knowledge of successful collaborative projects spreads to build broad community support for further training.

Experience with the STM has shown that the number of participants in training and the number of projects they develop have been greater in the replication than in the initial training. This may be due to experience with the model and the timeliness of clergy and agency staff collaboration to extend services and programs to older persons.

NETWORKS

Maintaining contact and nurturing the networks that have been created will pay many dividends. Contact with graduates by the educational institution and the lead Area Agency on Aging staff will provide one level of support to graduates of the

training. Follow-up from the advisory committee will reinforce awareness of the collaborative work they are doing. Requests for use of their training and experience to assist new training or collaborative efforts will extend and nurture the graduate's skill and knowledge base.

CONTINUING EDUCATION

Contact with graduates can yield information on additional skills and resources that may be met by advanced continuing education programs. This, additionally, provides a way to explore the impact of the initial training on continuing community collaboration and on-going work of clergy and agency staff. Workshops and special statewide sessions around current aging issues or training needs can nurture the network relationships while meeting training needs of graduates.

SUMMARY

The Statewide Training Model has the potential for:

1. Delivering a Continuing Education Certificate in Gerontology in the field of Religion and Aging for clergy and aging agency staff;

2. Making a statewide impact on extending services and programs to older persons;

3. Creating networks for collaboration on local and state levels;

4. Providing a pool of trained leadership in communities and within the state for future collaborative efforts and continuing education programs.

The dividends for communities, congregations and agencies can be extensive and very exciting.

APPENDIX A

SELECTED EXAMPLES OF PROJECTS

From 1988 Program

1. Sterling Silver in Savannah, a project which organizes church volunteers to provide personal care and homecare on a limited basis for persons who do not qualify for medicaid or medicare and are unable to secure such services.

2. What Will Happen To Mom And Dad? Can We Talk?, a workshop on intergenerational/interpersonal dynamics of decision making about housing that has energized an established church to discover a new mission to older persons. The workshop was videotaped for use with other groups.

3. Slide Presentation--Services Available was designed by some staff of an area agency on aging for the purpose of addressing the religious communities in the Area Planning and Development Commission APDC area. The project involves a slide presentation, dissemination of literature and technical assistance in developing programs in or between congregations.

4. Establishing A Kitchen For South Georgia. Two staff members of the SOWEGA Council on Aging and a minister in Moultrie Collaborated to establish a new kitchen in the Moultrie Senior Center donated by church and community resources to serve more and better meals to seniors through several satellite centers across south Georgia.

5. Sharing Of Life Skills is a project through which older women in a north Georgia mountains senior center teach, assist and share as friends with young pregnant teens.

6. Friendly Visiting is a training program in Bartow county targeted to frail elderly persons in this rural county. Several agency staff persons collaborated as a team to mobilize efforts of church groups, police and fire departments and community politicians to establish an ongoing program.

7. The Golden Community Club began when a minister serving two small churches with a large older membership, not served by the area council on aging, initiated the club to develop programs for themselves. Through a weries of community workshops on healthcare issues, consumer fraud, weatherization, and other topics, the group has expanded to a wider membership from the two communities and very active older person leadership.

8. A Representative Payee Program for assistance in managing SSI and Social Security checks. A Department of family and Childrens Service DFAC staff person and a minister are recruiting volunteers in churches to be matched with persons identified by the DFAC staff person for this program.

9. Respite Care For The Caregiver. Two participants, a minister and an Office of Aging staff person are putting together a workshop and continuing program for caregivers to give support and counseling as needed.

10. Engaging In Aging, a workshop to stimulate community, especially church awareness, of older person needs and existing services that can be matched for new programs to serve older persons.

11. Interviews for Oral Biograghies, a training program for church and community volunteers to preserve the personal histories of older persons.

12. A Library Resource Center in a small community is located in a church but open to the whole community. It will contain all sorts of agency resource materials, magazine and journal articles on aging, and books in gerontology.

13. Hearing Screenings and Hearing Impairment, a cooperative venture of a local church and DFAC office. The program was so successful in this small town that other health screenings are planned and will be promoted throughout the community.

14. An Aging Ministry For a Presbytery. The project is identifying physical, spiritual, intellectual, social and psychological needs of older persons and developing strategies to meet those needs. Five to seven churches in the presbytery have been targeted. Survey instruments, workshops, a course for seminarians, and planned resource exhchange between churches are some methods being used.

15. Discovering Needs and Solutions: The Older Adult Task Force in the Local Church, involves development of a new older adult ministry by older persons for themselves. Forums, trips, and new knowledge of services in the church have resulted as older persons have assumed leadership and responsibility for the program. There is now new leadership and resources affecting other parts of the church ministry.

16. Bringing The Elderly To The Marketplace, has a focus on employment in Augusta. The intention of the project is to make use of the old city market as a place where older persons can use their existing skills in chair caning, appliance repair, sewing, or learn those and other skills. The project is seeking to get the city of Augusta to renovate the old market place, secure merchant cooperation

to train or put to work 40 older persons who would rent space and pay taxes as other businesses.

17. Alzheimer's Support Group for a Georgia Mountain area has been developed through cooperation of several organizations to identify potential members and provide resources.

18. Nursing Home Visitation, a program to provide education and training to church and community volunteers who will visit regularly. There is a need to sensitize those persons to the needs and abilities of nursing home patients and assist them in maintaining their enthusiasm for the effort and consistency of visitation.

19. Education For Wellness, a series of wellness programs for one congregation making use of a number of aging agency resources.

20. Identification of Needs of Older Persons involved development of a simple to use survey instrument for churches to determine where to start with programming for older persons and matching existing services.

CHURCH, SYNAGOGUE AND COMMUNITY

1989 Project Summary

Atlanta, GA

21. Assistance with medicare forms (need expressed by a group of older persons in a church). The plan isto train group members using resources of Life Enrichment, AARP or other agencies at the Unitarian Universalist Congregation of Atlanta.

22. The project will develop awareness of available programs and services among older persons in churches. There will be provision of information on all kinds of programs, services, assistance and encouragement for chuch development of senior adult program.

23. The project is focused on an adult mobile home community that is isolated from larger community. They will make a visible contact from First Baptist Church of Kennesaw re: transportation, social interaction, and other needs.

24. The Methodist Church in Hogansville and the Hogansville Senior Center will cooperate on a program to expand the impact and outreach of programs and services to the community, for example, Golden Olympics Day.

25. A resource guide and checklist will be developed for arrangements and details to be made after the death of a person re: funeral, cemetery, financial accounting, probate, Social Security Administration, or other needs in the metropolitan Atlanta area.

26. Care for the Caregivers, is a once-a-week respite program by church members for 8 caregivers. It will involve worship, group support, self-awareness, encouragement and a fellowship meal.

27. The project develops small group experiences to share skill in creative expression and personal growth.

28. The project will begin non-profit organization, Building Together, Inc., in order to link resources for homes and relationships with needs among the older population.

29. A visitation program to the elderly in 3 parishes in the Marietta-Roswell area will involve planning, recruitment and training of volunteers.

30. The project will develop congregational programming involving seniors in their church including activities, information on social services available, visitation of the home bound and homeowner help.

31. A target area of 9 churches in Scottdale, DeKalb county, has been identified for a program to increase an understanding of Medicare on the part of older persons and clergy.

32. The project will set up a program to:

    a. compile information on resources available;
    b. communicate information to church members;
    c. develop church programs for transportation, homebound care, prayer groups, Bible study;
    d. provide social functions for friendship and learning;
    e. tie in with agencies.

    The focus is on DeKalb and Fulton counties.

33. The project will develop awareness of and commitment to programs in the church that reaches physical, mental and spiritual needs of older persons.

34. Interviews For Oral Biographies. The project will develop a training program, recruit volunteers and start a library to preserve the personal histories of older persons. The target is 40 persons in the Rome, GA area.

35. The project will establish a senior citizens organization in Saint Peter and Paul Parish which will include an outreach to the homebound and those in nursing homes within the area.

36. The project will establish an Older Adult Task Force in the Cokesbury United Methodist Church with older persons involved in the planning, development and leadership of the group. It includes the Toco Hills area.

37. The project will establish a Shepherd's Center for Korean Churches in the metropolitan Atlanta area. Work will begin with metropolitan interdenominational organizations of Korean churches and the organization of Korean pastors as a base of support. The program will begin with a few churches then expand.

38. The project will survey the community around the Eastside Baptist Church, Marietta in order to determine the needs for establishing ministry for senior adults, then develop strategy for projects and programs through networking with agencies.

39. The project will develop transportation for seniors to The Temple for services and programs, then develop greater variety of programs and services for older persons. The project teams will serve as consultants to Temple staff and committees and recruit volunteers as needed.

40. Dissemination of the Atlanta Regional Commission Resource Directory to church staff and volunteers in the 7 county Atlanta Region who will work as liaision persons to connect persons and services will be the focus of this project.

41. GEM - God's empowering Ministry is an intentional ministry to the "shut-in" and bereaved older persons in St. Anne's Catholic Church. Through networking with persons in and out of the Aging Network course, Sister Mary Alice Lovett has brought the world into the lives of some 35 shut-ins and 11 bereaved persons. Some 20 volunteers from the church make weekly contact with these persons. Through agency networking, new services have been made programs of the church, assistance from the Baptist Church telephone reassurance program, new religious materials are available to the shut-ins (some 12 of them) to engage in ministry with other shut-ins through a telephone prayer line they started as well as contact through cards and notes.

42. BROWN BAG OF COLUMBUS: Food for the elderly, a program started in 1987, provides a bag of groceries in the in the third week of the month to eligible persons 62 or older based in U.S. government guidelines for commkodity distribution. The food is made available through the Interfaith Food Bank and funded by churches, civic organizations and individuals.

This project focuses on involving at least one church in this program in depth through two stages:

Stage 1
a. Enlist church members to sponsor individuals in the program @ $3.00 per person a month for the remainder of 1989;
b. Each sponsor volunteer time at the distribution site each month;
c. Encourage some personal involvement with the person sponsored (e.g. birthday cards, telephone calls, transportation, etc.);

Stage 2
a. Evaluate experience at end of 1989;
b. Expand sponsorship program through work with other churches.

43. Old Fashioned Day in the Park. Agency participants from the Columbus Parks and Recreation Department networked with the Medical Center Circle of Care program and several senior centers to provide a two day focus on wellness in conjunction with a business community Prime Time of Your Life Exposition. The events included a wellness walk, demonstration of folk arts, table games, food and Golden Olympic Events. Churches are involved in recruiting older persons to participate.

44. Telephone Reassurance Program. This project extends an existing program of the Columbus Health Department to persons not otherwise reached by the program. Volunteer callers and persons to be called have been secured through the Wynnton United Methodist Church. The callers will be trained by the Health Department. Home-bound persons will minister to others through their calls. The ministry is to the Wynnton neighborhood, not just the church.

45. Intergenerational Sharing through visits to senior adults by young persons for sharing of activities as well as just visiting. The program will begin in one large church with recruitment screening and training of visitors but extend to a larger area. The program will require a commitment of time from each visitor.

46. Extension of The Harris County Senior Center Services and Programs to persons who need the program but are unaware or unable to participate, and in the process improve the quality of life for older persons in the county. Through networking between church and business groups three sponsoring groups are providing volunteer leadership and exploring resources to develop an activity program and other services. A needs assessment has been completed. Additional sponsorship is being sought from churches and

civic organizations.

47. A Comprehensive Directory of Services available to the elderly through churches, synagogues and social service agencies. A county wide survey of 426 churches and synagogues has been made and data is being complied including agency information. A sponsor to publish the directory is being secured and the directory may be distributed through the United Way. There are plans to expand the directory to an eight county area next year.

48. Establish an older adult fellowship in a small community to 1800 and connect it with a rural health clinic/hospital to provide education, information health screening services for this group. Networking between ministries of two churches and staff of the hospital and clinic as an advisory committee has laid the foundation for the project. Identification of older adult leadership and church community resources for transportation, subsidy for meeting meals, and recruitment of persons has been made. The program will begin in June, 1989.

49. Patient Information Supplement for Older Adults and Their Families for persons entering the Bradley Center Hospital. The purpose is to decrease patient and family anxiety and stress about serious hospitalization of an older person. The content covers hospital expectations of family and patient, major concerns of senior patients, services the hospital offers, ways families can best help older family members and a sample daily patient schedule.

50. Respite Care for Alzheimer Caregivers to attend an Alzheimers Family Support Group on a regular basis. Volunteers will be recruited from the local churches by members of an existing Alzheimers Support Group and trained by the staff or representatives of the Alzheimers Disease and Related Disorders Association. The program has started with the cooperation of three local churches who have recruited volunteers for the training and designated representatives to function as liaison between support group leaders and respite care volunteers.

51. Manual for Assistance to Churches in Developing programs for Aging Adults. The expected results of this manual to be completed and printed by July is:

    a. to increase intergenerational activities in churches;
    b. to improve communication between the "sandwich generation" and the elderly;
    c. to educate those in the sandwich generation about support services;
    d. to develop workshops within churches on dealing with death and dying.

APPENDIX B

FY'90 Update

Area Plan on Aging

Atlanta Region
Change in 60+ Population Distribution

	1980	1985
Clayton	5.4	5.7
Cobb	13.1	15.0
DeKalb	26.1	26.4
Douglas	2.6	2.6
Fulton	44.1	40.1
Gwinnett	6.7	8.1
Rockdale	2.0	2.1

Designated Priority Services
Older Americans Act

- Access Services
  - Information and Referral
  - Transportation
  - Outreach
- In-Home Services
  - Homemaker
  - Chore Services
- Legal Services

FY'89-'90 Contract Agencies

- County Based Agencies
- Specialized Service Agencies (Regional)
- Demonstration Project Agencies (In home service for Elderly)

State Funding Formula

Criteria	Assigned Weight
60+ Population	60%
60+ Pop./Below Poverty	20%
75+ Population (85 Estimates)	6.66%
60+ Pop./Rural Areas	6.67%
60+ Pop./Minority	6.67%

New Initiatives FY'89-'90

Expanded Information and Referral Services

- Corporate Consultation Services
- 24 hour information line
- Service Directories

Gatekeeper Project
(Georgia Power/Atlanta Gas Light)

Employment Resource Center
(The Travelers/Days Inn/YWCA)

New Initiatives FY'89-'90

Resource Development Project (VISTA)

ACCESS Project

- o Corporate Service
- o Private Pay
- o Volunteers Recruitment

Wellness Projects

New Initiatives FY'89-'90

New Service Development

- o Money Management
- o Provider Guidelines

Education Seminars

Catastrophic Care -

Long Term Care -

Long Term Care Insurance -

New Initiatives FY'89-'90

Expanded Advocacy Activities

- Coalition of Advocates for Georgia's Elders
- Senior Week
- Silver-Haired Legislators
- Telephone Tree

Development and Implementation of Expanded In-home Service (Title III D)